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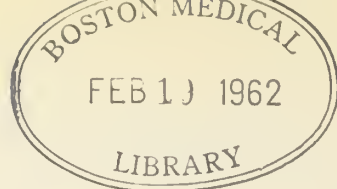
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FREEDOM IN MEDICINE

The Author, *President, American Medical Association*

Mr. Speaker and Members of the House of Delegates:

Almost six months have elapsed since we last met to deliberate and act on medical affairs. The time has passed quickly, but not quietly.

The rumble of war and revolution has resounded in our ears. The din from political battles has been deafening.

All of us . . . sooner or later . . . learn that today's events do not just swirl around us, but involve each of us. As doctors we cannot get away from them by claiming that our only interest is in the sick, and that we cannot be bothered by political, social and economic problems. These matters demand attention from the doctors as well as the lawyer, the businessman, the newspaper editor, the labor leader and the worker.

If we are concerned about what happens on the international, national and local fronts—and we should be—then certainly we cannot afford to be disinterested in what happens in our own area of health and medical affairs. Yet there is apathy in our ranks.

REPLACE APATHY WITH ACTIVE, UNITED PROFESSION

Today there is a greater need for a united, forceful and informed profession than ever before. We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed.

For example, in a few days Public Law 569, the bill providing medical care for military dependents, becomes effective throughout the land. Contracts already have been signed with the government by

DWIGHT H. MURRAY, M.D., *Napa, California*

the majority of our state societies. No longer can any doctor claim that this law does not affect him. No longer can he say that government laws really are not changing the practice of medicine.

Public Law 880, better known to all of us as HR7225, is another case in point. Medicine now is facing the problem of protecting the taxpaying public from abuses and of cooperating with the government to carry out the provisions of the law. The law is now on the books, and we must provide the leadership necessary to make it work as well as possible.

It was encouraging to hear Ezra Taft Benson, Secretary of Agriculture, say last week before the American Association of Land Grant Colleges and Universities:

"Sooner or later, the accumulation of power in a central government leads to a loss of freedom . . . Raids on the federal treasury can be all too readily accomplished by an organized few over the feeble protests of an apathetic majority. With more and more activity centered in the federal government, the relationship between the cost and the benefits of government programs becomes obscure. What follows is the voting of public money without having to accept direct local responsibility for higher taxes. . . ."

"If the present shift of power from state to federal authority which started 25 years ago is allowed to continue, the states may be left hollow shells."

It was encouraging to hear such comments from a member of the President's Cabinet. I only wish that all members of the official family, and more important, every member of the United States Congress, felt the same way.

The expression of this philosophy, with which medicine so heartily agrees, sounds good, but put-

Delivered before the House of Delegates of the American Medical Association at Seattle, Washington, November 27, 1956

ting it into practice is the thing we are really interested in.

Today the medical profession along with business and industry is caught between those who desire to promote sound government programs and those who desire even more intensely to perpetuate party power. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedoms. Medicine must do its utmost to reverse this trend.

MEDICAL FREEDOM ESSENTIAL

In my travels around the country as your representative the last 18 months, I have seen little dissension or rancor within our ranks. However, I must report that I have seen too much complacency over governmental encroachment into medical affairs. And I am deadly serious when I say to you that apathy by the few, or by the many, can be detrimental to all.

No nation can merely reap the benefits of freedom; it also must sow seeds of freedom.

In medicine the situation is the same. If an apathetic medical profession takes its freedom for granted, it will be the beginning of the end. A strong, free profession must work for freedom so that it may live in freedom. And history tells us once medicine loses its freedom, other fields of private endeavor are immediately in danger.

I do not wish to paint a dark or distorted picture of medicine's free status and its stature in America today. But I do believe words of caution and an appeal for vigilance are in order.

The road of apathy and disunity can only lead to disorder and perhaps disintegration, and we must sound a warning to all our colleagues who don't care, or who are pulling in the opposite direction. The road of alertness, action and unity is the proper road for all of us to be traveling together.

If I had just one wish for the coming year, it would be to command the time and talents of the 160,000 physicians in the American Medical Association. I would set us all to the task of emphasizing and reemphasizing the absolute necessity of patient and professional freedom.

PATIENT'S RIGHT TO CHOOSE HIS DOCTOR

I believe it is one of our prime responsibilities to prove to our patients that their right to choose their doctor is a most important one.

Free choice brings a bond of confidence between doctor and patient which no compulsory medical system can create. It means that the patient knows the physician will be interested in him as a person, not as just a serial number or the 2:45 appendicitis case.

For the doctor free choice means that the patient has selected him for his abilities, training, sincerity and personality. When a patient comes into my office, I know he has made a choice. And from that moment there begins a physician-patient relationship of the highest order. To me the patient is someone special, and I in turn hope that I am someone special to him.

Once the patient has made his choice, the physician automatically assumes an unqualified responsibility to the patient. No system of medical care that uses a third party to bring doctor and patient together can match our kind of cooperative performance for the treatment of illness, the cure of disease and the betterment of the patient's health.

Freedom to select a doctor is part of everyone's great freedom to choose—to choose what he wears and eats; where he works and worships, and how he votes. Take away any part of this freedom and great damage is done to our democratic system.

FREE CONDUCT IN MEDICAL TREATMENT

Another freedom closely tied to freedom of choice is freedom in the conduct of medical treatment.

At the recent meeting of the World Medical Association in Havana, Cuba, Dr. Rolf Schoegell of Germany made a stirring defense of free conduct of medical treatment. He told us that the medical profession believes the attending physician alone is competent to decide what measures he deems necessary and will apply in order to bring about the desired improvement. He warned too of the danger of excessive restriction on the freedom of the patient and the attending doctor.

Yet the trend toward extending social security in the medical care field has been steady and has accelerated since the end of World War II.

The dangers of shifting responsibilities for medical care from the patient and doctor to the government are obvious. The caliber of medical care cannot be as high when both patient and doctor are dependent upon government. Initiative succumbs to dictation, and self reliance is replaced by the crutch of government.

We do not deny that there is an area of legitimate concern by the government for the health and welfare of the people. But each year government seems to extend that area. We get some idea of this expansion from the new federal medical budget.

This year, according to our Washington office, the average family will be paying \$54.61 for the U. S. Government's health and medical activities. And the total expenditures this year amount to 2½ billion dollars—290 millions more than last year. Even in an overall federal budget of 61 billion dollars, the total health cost of 2½ billions is not insignificant. It is a billion dollars more than the cost of running the Commerce Department, half a billion more than the Agriculture Department and six times more than the Interior Department's budget.

Many expenditures obviously are necessary to keep up our unsurpassed public health standards, and research may pay rich dividends in scientific discoveries. But there is no doubt that much money is being spent on medical activities that should not involve government participation.

The trend is to spend more and more government money on health and medical matters because it is good politics. Apparently many Americans still want to see government in the role of a big brother, dishing out so-called gifts and bargains under the guise of benevolent economic planning.

I believe it is our duty, as it is everyone else's, to combat the attitude of "what's in it for me?" and to promote the long-honored creed of "what's best for all Americans and our free society." I think that a nation can drift into state medicine inch by inch just as surely as if the scheme were foisted upon a people overnight. The "drift" method may take longer but the result will be the same.

So it is time all of us sounded the alarm against soft and superficial security and against the invasion of personal responsibility. It is time we stood up together for militant freedom and for full rights and responsibilities of the individual.

BELGIAN DOCTORS TURN BACK GOVERNMENT

There is no better example of what a unified medical profession can do than in the story of the recent fight of the Belgian doctors against the government's proposals for a state service of medicine.

Without consulting the medical profession the Belgian government proceeded to draft rules and

regulations of health to be incorporated in the nation's social security legislation. Under the proposals doctors were sign an agreement to abide by the present rules and any later regulations. For the patient there would be the usual red tape in getting medical care.

When the Belgian doctors learned of the scheme, they met in conference with the government. They told the government what they wanted and what they would not accept. The government agreed.

For several months everything was quiet. Then the Belgian doctors suddenly read about the new health bill that the government was sending to Parliament. It was quite contrary to the earlier agreement worked out by the profession and the government. But the bill was passed quickly.

The Belgian medical profession protested and said it would not be placed under the Ministry of Labor. Instead the doctors proposed to set up their own plan of medical assistance.

Before long, the government saw that the medical profession meant business and that the doctor's plan was an attractive one. So it declared that its own bill was not in force and could not be in force without the consent of the medical profession.

To me this fight against legislative intervention in medical care is excellent evidence that the profession can defend itself if it unites to defend the basic principles of freedom and if it offers constructive proposals. By using the Belgian national motto, "in union there is strength," the medical profession showed doctors everywhere that dangerous government plans can be turned aside by the strong.

I also read recently in the *Journal of the World Medical Association* of the fight of the medical profession of Malta against a British government scheme to introduce a full-time salaried medical service, without the right of private practice, on an island dependency of Malta. Here again the doctors reacted with unity and strength, and successfully thwarted the government's plan.

There is a lesson in these stories from Belgium and Malta. They prove that a unified profession has a great political power for good—the good of the patient, the doctors and the nation.

CONFIDENCE OF PATIENTS, UNDERSTANDING OF LEGISLATORS NEEDED

While we are developing unity within our own ranks, I believe it is equally important to continue

to build up the confidence and respect of our patients, and to make our legislators aware of the necessity for freedom in medical practice.

Let us never reduce the quality of service we render to our patients, and never lose the personal touch in medicine. Where there is any opportunity to improve upon our medical care, let us seize it and show our abilities to do an outstanding job. Satisfied patient customers will give us deserving support when we need it.

We also should realize that the destiny of medicine can be determined to a large degree in the halls of Congress. If this be true, then it is even more important that we take an even greater interest in those who elect the Congressmen. Sympathetic understanding of our position by federal legislators through the voting public will be an insurmountable deterrent to the forces supporting state medicine.

The day has come, gentlemen, when we can no longer look upon medical economics and social

changes merely as issues to be considered during our limited leisure hours. Our interest in them cannot be superficial or intermittent.

We now must pay daily attention to these matters. Medical socio-economic affairs can no longer be just incidental with us. They must be a vital part of our life and of our profession.

Each of us, I believe, should dedicate himself to the words included in the oath of office taken by presidents of the AMA.

"I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans."

As doctors, representatives to the AMA and as spokesmen for the AMA, let's remember these words and live by them. And to alter a phrase of President Lincoln's only slightly: Let's make common cause to keep the good ship of medical freedom on this voyage, or nobody will have a chance to pilot her on another voyage.

EPIDEMIOLOGY OF ACCIDENTAL DEATHS AMONG COLLEGE STUDENTS

HENRY M. PARRISH, M.D., *New Haven*

The Author. *Fellow in Public Health and Assistant Physician, Department of University Health, Yale University, New Haven, Connecticut*

SUMMARY

Accidents are the leading cause of death in college students. A recent survey of 209 student deaths at Yale University from 1920-1955 showed 91 (43.8 per cent) resulted from accidents. Motor vehicle accidents, alone, accounted for 49 (23.6 per cent) of the student fatalities.

An epidemiological analysis of accidental deaths showed that more deaths occurred out of State and in Connecticut outside of New Haven, than in the college

community. There were more fatal motor vehicle accidents in students less than 22 years of age than in the older age groups, and more in undergraduate students than graduate students. Motor vehicle accidents resulting in death occurred more frequently on the weekends during the school year, while airplane accidents and drownings were more prevalent during vacation periods.

Accidents are the most important public health problem on the college campus at present. Deaths due to infectious diseases have declined since the advent of antibiotics, but accidental deaths have shown no such decline and remain as the number one "killer" of our college youth.

From the Department of Public Health and the Department of University Health, Yale University School of Medicine, New Haven, Connecticut. This paper is based on a study in partial fulfillment of the requirements for the degree of Master of Public Health

INTRODUCTION

Accidents are the leading cause of death in college students. A recent survey of the causes of death of 209 students at Yale University from 1920-1955 revealed the following most common causes of death: (1) accidents—43.8 per cent; (2) suicide—12.0 per cent; (3) heart and circulatory diseases—7.7 per cent; (4) pneumonia—7.2 per cent; and (5) central nervous system infections—6.3 per cent. Diehl and Shepard¹ made a similar study of deaths in 327 college students from nine universities during the ten year period from 1925-1935. The leading causes of death in their study were: (1) accidents—26.3 per cent; (2) heart and circulatory diseases—10.1 per cent; (3) suicide—8.0 per cent; (4) pneumonia—7.3 per cent; and (5) tuberculosis—6.4 per cent. One may conclude, from these two studies, that accidents account for more college deaths than any other cause.

CLASSIFICATION

Accidents constitute a major public health problem on the Yale campus. Approximately 44 per cent of all student deaths from 1920-1955 resulted from accidents. Motor vehicle accidents alone accounted for 24 per cent of the deaths, while all other accidents produced 20 per cent of the student fatalities. Accidents accounted for more deaths than the next five most common causes of death combined. The individual causes of accidental deaths are classified in Table I.

TABLE I

CAUSES OF ACCIDENTAL DEATHS OF YALE STUDENTS 1920-1955

CAUSES	NUMBER OF DEATHS
Motor vehicle	49
Airplane	16
Drowned	15
Falls	5
Burns	2
Firearms	1
Electrocuted	1
Asphyxiated	1
Unclassified	1
Total	91

INCIDENCE

Information regarding the true incidence and prevalence of accidents in the college environment is scanty. Incapacity from nonfatal accidents is a significant problem. The American College Health Association and The National Safety Council under-

took a Survey of Accidents to College Students in 1953.² The results of this study showed an average of one student in nine was accidentally injured during the school year, and one injured student in eleven required hospitalization. Quite surprisingly, no deaths were reported in the 8,743 accidents studied!

The incidence of accidents on the Yale campus is not known, but the magnitude of the problem is emphasized in Table II, which summarizes the annual reports of accident insurance income. If these results can be accepted as approximately the actual incidence of accidents, then one student in four at Yale is involved in an accident requiring medical attention each year.

TABLE II

COMPARATIVE CLASSIFICATION OF YALE ACCIDENTS

	1951-52	1952-53	1953-54	1954-55
Baseball	72	67	53	69
Basketball	186	159	148	137
Bowling	2	3	0	0
Boxing	10	11	15	17
Crew	31	40	59	39
Fencing	7	12	1	7
Football	509	572	515	423
Golf	4	7	5	7
Handball	7	13	21	25
Hockey	85	79	77	69
Ju-jitsu	1	2	2	9
Lacrosse	48	58	65	48
Ping Pong	1	3	1	4
Polo	3	3	8	3
Rugby	7	8	8	19
Skiing	66	73	70	72
Soccer	70	76	88	84
Softball	22	11	7	18
Squash	52	58	53	60
Swimming	19	23	17	33
Tennis	16	22	20	26
Track	43	30	46	50
Volleyball	5	3	4	0
Wrestling	79	52	58	53
Miscellaneous	845	837	747	787
Airplane	0	0	0	0
Automobile	40	39	29	48
Bicycle	19	10	9	17
Motorcycle	4	1	0	4
Total No. Accidents....	2,253	2,272	2,126	2,128

LOCALITY

In planning a program for accident prevention it is necessary to know where the accidents occur. In this study we are concerned with accidental deaths. Are most of the deaths taking place on the college

campus? Does the college community provide a safe environment? The locality of 91 accidental deaths is tabulated in Table III. Only eleven (12 per cent) of the accidents resulting in death took place in New Haven. Twenty-four (26 per cent) occurred in Connecticut and fifty-six (62 per cent) happened outside of Connecticut. Of the eleven deaths in New Haven, seven were from motor vehicle accidents, two from falls, and one from burns. All of the deaths from airplane accidents took place out of the State, as did 12 of the 15 drownings.

TABLE III

LOCALITY OF 91 YALE STUDENT ACCIDENTAL DEATHS 1920-1955

TYPE OF ACCIDENT	NEW HAVEN	CONNECTICUT	OUT-OF-STATE
Motor vehicle	7	20	22
Airplane	0	0	16
Drowning	0	3	12
Others	4	1	6
Total	11	24	56

A geographical study of fatal motor vehicle accidents in Connecticut shows that only four occurred within the city limits of New Haven, though three other deaths which took place in Hamden and North Haven may be considered in the college community. Eight of the remaining twenty automobile accidents which occurred in Connecticut, outside of New Haven, were on the Merritt Parkway. The majority of accidental deaths from motor vehicle wrecks occurred on the main highways between New York City and Boston.

Only 12 per cent of deaths from accidents occurred in New Haven, but this does not imply that most nonfatal accidents occur away from the college campus. There is no reliable information on the total number of accidents, but one may conclude that most accidental deaths occur away from the college community.

TEMPORAL RELATIONSHIPS

Accidental deaths have remained rather constant in number at Yale during the past 35 years. From 1920-1929 there were 28, from 1930-1939 there were 21, from 1940-1949 there were 27, and from 1950-1955 there were 15 deaths. It has been estimated that there will be approximately 28 to 30 deaths from accidents during the period from 1950-1959. If accidents continue at this pace they will remain the number one "killer" of college students.

There is a significant increase in the number of

accidental deaths, especially from automobile wrecks, during the period starting Friday, when classes are dismissed, and ending Monday, when they resume. The day of the week on which accidents resulting in student death occurred are listed in Table IV.

TABLE IV

DAY OF THE WEEK FATAL ACCIDENTS OCCURRED
YALE STUDENTS 1920-1955*

DAY OF WEEK	MOTOR				TOTAL
	VEHICLE	AIRPLANE	DROWNED	OTHERS	
Monday	3	1	1	0	5
Tuesday	1	0	1	0	2
Wednesday	0	0	0	2	2
Thursday	3	1	4	1	9
Friday	9	0	1	2	12
Saturday	20	2	1	3	26
Sunday	13	12	7	3	35

*Including holidays and vacations

The data in Table V show that student deaths took place during the following periods of the year: 8 during the school week; 36 over the weekend; 18 during the Christmas holidays; and 29 during the summer vacation period.

TABLE V

PERIODS OF TIME RELATED TO ACCIDENTAL DEATHS OF YALE
STUDENTS 1920-1955

PERIOD OF TIME	MOTOR				TOTAL
	VEHICLE	AIRPLANE	DROWNED	OTHERS	
School week	3	1	2	2	8
Weekend school year	28	1	3	4	36
Christmas vacation	4	12	1	1	18
Summer vacation	14	2	9	4	29
Total	49	16	15	11	91

Airplane accidents were most frequently the cause of death during the Christmas vacation period when students are more prone to use aircraft as a means of transportation. Eleven students were killed and twelve others seriously injured when a chartered transport crashed in Seattle, Washington on January 2, 1949. They were returning from Christmas vacation at the time of the tragedy. Another Yale student was one of fifty-six victims of a holiday flight which ended in a catastrophe at Newark, N. J. on December 16, 1951.

Ten of the fifteen deaths due to drowning occurred during the vacation periods, one during

Christmas vacation while ice skating and the other nine during the summer vacation while swimming or boating. In contrast to the heavy toll of student lives lost during vacation periods from airplane accidents and drowning, motor vehicle accidents produced more fatalities on weekends during the school year.

It seemed desirable to know what time of day the automobile accidents occurred, but this information is not so important for the other causes of accidental death. Twenty-seven of the fatal motor vehicle accidents occurred during the period from 12 P. M. to 6 A. M., nine happened from 6 P. M. to 12 P. M., and only four during the 12 hour period from 6 A. M. to 6 P. M. Information concerning the hour of the accident could not be obtained for nine of the deaths.

AGE AND CLASS OF STUDENTS

The largest number of deaths from accidents (25) were in students 20 years of age. This age group is usually in their junior year at Yale. Of the 91 deaths from accidental causes, 77 (85 per cent) were in students 22 years of age or less. Part of this difference in incidence can be explained by the fact that there are more undergraduate than graduate students. Nevertheless, there appears to be a significantly higher death rate from accidents in the lower age groups. Table VI illustrates the relationship between the age and class of the students and number of accidental deaths.

The age of the student and his academic class in college are closely related. There were 21 freshman class deaths, 21 sophomore class deaths, 26 junior class deaths, and 13 senior class deaths, as compared with 10 deaths in graduate and professional school students.

ACTIVITY AT THE TIME OF DEATH

Most of the students who died from accidental causes were engaged in either travel or recreation. There were 61 students who died while traveling, 49 in motor vehicles and 12 in airplanes. Twenty-two were engaged in recreation at the time of death: fifteen died while swimming or boating, three from falls, two while piloting their own private airplanes, one was electrocuted while climbing a train trestle, and one was burned to death in a theater fire. There were three deaths at the school place of residence, two in the home residence, and two died while carrying on their occupation.

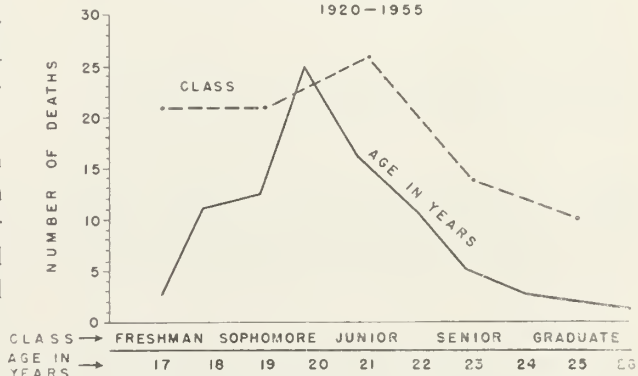
DISCUSSION

This study considered some of the epidemiological factors in accidental deaths of college students. The study was undertaken because accidents are the most common cause of death in college students, and information relating to this subject is lacking.

Most people regard the college campus as a protected environment which shelters its inhabitants from the hazards of modern life. In general, the citizens of the college community are adolescents and young adults in good health. Of course there are exceptions to the rule, but they are a minority. The crude death rate of Yale students is lower than the crude death rate for the same age group in the general population. Some of the factors which probably account for this are: college students are, for the most part, young adults between the ages of 17-25; the majority of the students are from an average or above-average socio-economic group; most students eat in the college dining halls where nutritious meals are served; Yale students are a carefully selected intellectual group who are better in-

TABLE VI

AGE AND CLASS OF YALE STUDENTS AT TIME OF ACCIDENTAL DEATH 1920-1955



formed about health matters than a comparable group of the same age in the general population; and college entrance examinations help detect disease and channel students with medical problems for special care.

This study clearly points to accidents as the number one public health problem on the college campus today. Accidents accounted for more student deaths than the next five most common causes of death combined. Accidental deaths have continued at a high peak since 1920, while deaths due to infectious

diseases have been on a decline. There is no evidence from this study that accidental deaths have increased over the 35 year period studied. Actually, there are no reliable figures of the true incidence of accidents at Yale, but preliminary data suggest that one student in four at Yale has an accident each year requiring medical attention.

Accidents account for more deaths in the age group from 15 to 25 in the general population than any other cause.³ "Motor vehicle accidents cause more deaths than any other type of accident among persons under 65 years of age."⁴ These statements held true for Yale where 23.6 per cent of all deaths resulted from motor vehicle accidents. Most of the motor vehicle deaths occurred outside of Connecticut, and most of the ones in Connecticut happened outside of New Haven, the college community. Closely related to this finding is the fact that most of the fatal motor vehicle accidents took place over the weekends during the school year. The above

observations are probably related to increased student travel over the weekends. Since Yale is primarily a men's college and there are no girls' schools in the immediate vicinity, most of the undergraduates travel long distances in automobiles over the weekend to find young ladies to "date." Other students drive home to spend the weekend with their families.

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WHY DO ACCIDENTS HAPPEN?

BEFORE we can develop a really effective program to prevent auto accidents, we will have to learn far more than we now know about why such accidents happen.

The National Safety Council, while pointing out that most accidents result from a combination of causes, and that "few accidents are investigated carefully enough to determine exactly what their underlying causes were," estimates that in about 80 per cent of accidents, the most important single factor is the driver himself.

Bad weather, poor road conditions, and defects in cars do cause some accidents, but, generally speaking, such circumstances appear to be of minor significance compared with the mental and physical condition of the driver. And recent research indicates that the driver's physical condition is of less importance than his personality and his emotional

state. Many, if not most, accidents, this research suggests, are the result of wayward impulses and motivations, of faulty judgments and attitudes, of poorly controlled aggressiveness and competitiveness. Further study of personality and emotions in relation to driving probably would contribute much to the understanding and prevention of accidents.

Nearly two thirds of the drivers involved in fatal accidents in 1954 were speeding, driving while under the influence of alcohol, disregarding stop lights or signs, or otherwise violating the law, according to the Safety Council. The pertinent question is why do people drive too fast, drive after drinking, take risks in passing, or, in general, commit dangerous, careless, illegal, impulsive, or unfriendly acts when they get behind the wheel?

A small beginning has been made toward finding answers to this question. Several studies comprehen-

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ANONYMOUS

sively described by Dr. Ross McFarland and his associates at Harvard's School of Public Health have probed the personality and emotional characteristics of so-called accident-prone drivers and discovered such traits as emotional instability, impulsiveness, suggestibility, excitability, lack of a proper sense of social responsibility, aggressiveness, and intolerance of authority. Although fault may be found with the quality of this research in terms of controls and other safeguards, it may prove provocative enough to lead to sounder efforts.

"A man drives as he lives," says Drs. Tillman and Hobbs in an article in the *American Journal of Psychiatry*. "If his personal life is marked by caution, tolerance, foresight, consideration for others, then he will drive in the same way. If his personal life is devoid of these desirable characteristics, then his driving will be characterized by aggressiveness, and over a long period of time, he will have a higher accident rate than his more stable companions."

The trouble with the first part of this statement is that no human being is, at all times, cautious, tolerant, foresighted, and considerate of others. Even though we may be exemplary persons most of the time, there are certain moments, or longer periods, in the lives of all of us when we become temporarily impulsive, aggressive, or otherwise emotionally off balance. If we happen to be driving during one of these episodes—and if external circumstances favor an accident—then an accident is likely to occur.

As Dr. Edward Press, of the University of Illinois, puts it: "Just as almost all of us will respond with a neuroses or other nervous disorder to a sufficiently strong or repeated stress, so the average person under certain combinations of circumstances that occur frequently in our current civilization can become temporarily accident prone." Excessive fatigue, fear, worry, sleeplessness, irritability, preoccupation, headache, too much alcohol or other drugs—all may have this effect.

THE UNCONSCIOUS AT THE WHEEL

While the study of behavior and conscious mental activities by way of aptitude, intelligence, and psychologic tests and by clinical scrutiny of life histories and attitudes will increase our understanding of accident causes, our knowledge will be incomplete without more information about the unconscious and its influence on drivers. More than 40 years ago Freud said, "Psychoanalysis has concluded

from a study of dreams and mental slips of normal people as well as from the symptoms of neurotics, that . . . primitive [and] savage . . . impulses of mankind have not vanished in any individual, but continue their existence, although in a repressed state in the unconscious, and that they wait for opportunities to display their activity." For many people, the automobile apparently provides some of the most irresistible of such opportunities—especially with the current glorification of the high-speed car with its formidable horsepower, and fast-starting and quick-passing ability.

While, admittedly, the evidence for the great importance of psychological factors in auto accidents rests on a fragile statistical framework, the same is true of the evidence on physical defects of drivers responsible for auto accidents. The National Safety Council says that "only one out of 14 drivers involved in fatal accidents had a physical condition that could have been a contributing factor in the accident." Such statistics mean very little unless we know what is meant by a "physical condition;" and psychosomatic medicine has taught us that even major "physical" disorders often have important emotional components.

Some test of visual acuity is a standard device in almost all states for helping to determine the fitness of drivers. Such a test is of value in detecting impairment of ability to see far objects, and it undoubtedly deprives the near-blind of the freedom of killing themselves and others on the road. However, Dr. Leon Brody, of New York University, has been stressing for years the scant relationship between a driver's visual fitness, as measured by a conventional driver's license test, and his safety record.

PHYSICAL FITNESS

To be more meaningful, tests of driver vision should include peripheral vision, or ability to see objects on the sides while looking straight ahead: dark adaptation, or night vision; glare recovery; and ability to "accommodate," or shift from a far focus to a near focus (such as on a speedometer) and back. Color-blindness tests are of little importance, since even a person color-blind to red and green can readily learn to distinguish between red and green lights. Dark adaptation and glare recovery are particularly important in view of the fact that the fatal-accident rate per mile of travel is three times as high during the night as during the day. Dark adaptation is impaired by alcohol, carbon monoxide

and lack of vitamin A or oxygen. After age 45 or 50, there is a gradual decline in all visual functions, but what effect this decline has on auto-accident rates is unknown. Probably most older drivers compensate for it by more conservative driving practices.

Hearing acuteness also declines with age, but, again, there are no statistics to suggest a connection between hearing defects and auto accidents. Obviously, though, a deaf driver—or a driver with normal hearing who keeps his radio on full blast—has one less physical sense on guard to warn him of danger.

Driving skill by itself does not insure safety in driving, according to a study made by Dr. Brody in 1941. Many drivers repeatedly involved in accidents are skilled drivers, as determined by controlled driving tests. Some of these may get into trouble because they are convinced that they can safely take more risks than less skilled drivers.

Although people with an organic disease or disability—epilepsy, heart disease, or high blood pressure, for example—may be more prone to disabling symptoms while driving than healthy persons, this very fact may act as an incentive to more cautious driving on their part. At any rate, statistical evidence of a connection between such disorders and a high rate of auto accidents is lacking. Certainly, the emotional stresses associated with contemporary auto driving are not likely to be beneficial for a person with coronary artery disease or high blood pressure. No one knows how many heart attacks in innocent pedestrians and drivers have been caused by the foolish behavior of "healthy" drivers.

"Carotid sinus syncope" is a disorder caused by over-sensitivity of certain nerve tissue in the carotid arteries of the neck. A tight collar could conceivably produce faintness, dizziness, or even loss of consciousness in a driver suffering from this condition.

Other organic ailments—such as uncontrolled diabetes, kidney trouble, and neurological disorders—also can cause impairment of driving fitness. Undoubtedly more study of this problem is needed, and other states might well follow the lead of New York in requiring a doctor's certification of the fitness of persons with mental and certain physical disorders to receive a license to drive. At the same time, physicians should warn their patients with such disorders of the potential danger to themselves and others in driving.

Safe driving does not require hard muscular effort, but it does call for skill and mental concentration, both of which involve faculties that are subject to fatigue after several hours at the wheel. Visual fatigue also may be of considerable importance as an accident factor. It is good driving practice to take a rest or brief exercise after two hours or so at the wheel. This can also help to relieve road monotony and prevent the driver's falling asleep at the wheel—two frequently cited causes of auto accidents. Heavy meals, which dispose to sleepiness and fatigue, should be avoided by drivers.

CARBON MONOXIDE AND OTHER POISONING

The exhaust gas from auto engines contains carbon monoxide in percentages ranging from about 1 per cent to 7 per cent, and a car idling in a closed garage can produce enough of the gas in a few minutes to render the atmosphere deadly. Tests of passenger cars on the road have shown that carbon monoxide concentrations within the car can reach dangerous levels. The gas can come from leaks in the car's own exhaust system—such as blown-out gaskets, loose manifold and exhaust pipe connections, and holes in mufflers and exhaust pipes—and, in heavy traffic, from the exhaust of other cars. In streets where traffic is heavy, the concentration of carbon monoxide rises to about a hundred parts per million parts of air, enough to cause headaches, dizziness, faintness, weakness, and other toxic symptoms in many persons after an exposure of several hours.

Carbon monoxide also is one of the important toxic ingredients of tobacco smoke, and a person who smokes 20 to 30 cigarettes a day has from 4 per cent to 8 per cent of his hemoglobin blocked by this gas. There is little doubt that the carbon monoxide from other cars, your car, and smoking can combine to interfere seriously with driving efficiency.

Not long ago, Dr. Frank Dutra, the chief medical examiner for Cincinnati, urged that the carbon monoxide concentration in the blood of any driver involved in an accident be measured, predicting that such tests would pin point carbon monoxide as the cause of some otherwise unexplained fatal accidents.

Widely used sedatives, tranquilizers, stimulants, hormones (such as ACTH and cortisone) and anti-histamine drugs may cause disturbing side effects that impair driving skill, judgment, and attention.

The disabling effects of some of these drugs were brought out at the last highway safety research conference sponsored by the National Academy of Sciences and the National Research Council in 1954. Even ordinary doses of sedatives or stimulant drugs can evoke hostile and aggressive practices. Such barbiturate drugs as phenobarbital, Nembutal, and Seconal, when taken by order of a physician, are valuable for relieving nervous tension and promoting sleep, but taken at the wrong time or in uncontrolled amounts, they can cause physical and mental symptoms that interfere with driving ability.

THE EFFECT OF DRUGS

The stimulants—Benzedrine, Dexedrine, and similar amphetamine drugs—are frequently misused by drivers who do not realize that there is no substitute for rest and adequate sleep to assure effective exercise of their faculties. If misused, these drugs may cause irritability, excitement, and impairment of timing, coordination, and judgment. Abuse of the newer tranquilizing drugs, such as Miltown, Noludar, Thorazine, and reserpine, now frequently prescribed for common nervous disorders, can have equally harmful effects. The caffeine in cola drinks, coffee, and tea has a mild stimulant action which may improve driving alertness, but in excess or in sensitive persons, can impair muscular coordination and timing.

Since some antihistamine drugs are freely available without a doctor's prescription, many people take them indiscriminately for colds, grippe, coughs, and other acute respiratory infections. Other antihistamine drugs (Dramamine and Boramine, for example) are taken to control motion sickness. Among the more important possible side effects of these drugs are dizziness, difficulty in focusing the eyes, sleepiness, impaired reflex and reaction time, and disturbance of coordination and judgment—any of which obviously would be dangerous in a driver.

In the whole array of drugs capable of seriously interfering with driving skill and judgment, alcohol undoubtedly is the outstanding culprit. From the viewpoint of auto safety, the most important aspect of alcohol is its effect on the central nervous system. It is not a stimulant, as many people believe, but a depressant of the nervous system, sharing the characteristic actions of the general anesthetics. In small amounts, alcohol may improve mood and sociability, but, as Drs. Goodman and Gilman say in "The Pharmacological Basis of Therapeutics:" "Carefully controlled experiments have shown that alcohol increases neither mental nor physical ability; although the individual estimates his own performance as greatly improved, in reality, actual measurements show it to be inferior."

INTELLIGENCE PLUS CAUTION

To a certain extent, man can use his intelligence to overcome his physical and emotional shortcomings as a driver and the other threats to his safety on the road. He can make cars and roads safer, enforce traffic laws more rigorously, improve driving education, encourage training of visual and other skills useful in driving, and, probably most important, apply psychiatric, psychologic, and psychoanalytic research to the auto-accident problem. While Colorado has made a good start in this latter direction by requiring a psychiatric examination for persistent violators of driving laws, it obviously would be impractical to make such an examination a routine part of driver's license tests.

Until we find a way to screen out potentially dangerous drivers or to get more people to practice common sense and consideration for others on the road, it would be wise for each of us to assume that other drivers will behave discourteously, carelessly, aggressively, illegally, or stupidly—and to try to maintain a safety margin adequate to compensate for such behavior.

MYOCARDIAL INFARCTION IN YOUNG MALES

OSCAR ROTH, M.D. and ANNE V. PEPE, B.S., *New Haven*

THE reported incidence of myocardial infarction is increasing. According to vital statistics,¹ a total of 75,228 males and 31,937 females died of it in 1941 in the United States. This number increased to 154,871 males and 68,826 females in 1951. The incidence of this disease among persons under forty seems also to have increased definitely. Two thousand two hundred eighty one males and 893 females under the age of forty died of coronary artery disease in 1941 in the United States as compared to 3,687 males and 1,061 females in 1951 according to the records from the Bureau of Vital Statistics. In Connecticut alone, in the group under age forty, thirty five males and ten females succumbed to myocardial infarction in 1941 as compared to forty seven males and nine females in 1951. The overall incidence of myocardial infarction naturally is much higher than these mortality figures indicate. The overall immediate mortality rate for all ages was estimated at 33.8 per cent by Russek² in 707 cases and is most likely much lower in people under forty years of age.

Myocardial infarction, as is well known, may occur with or without preceding angina. If angina occurs, in young people, it may be overlooked or misdiagnosed, as too often myocardial infarction is thought to be a sickness of middle aged and old people. Recent reports of findings in young soldiers suggest that this assumption is wrong, particularly if one consider young male patients. For instance, Enos and his associates³ report the findings in unselected autopsies of three hundred young soldiers killed in action in Korea. Their average age was 22.1 years. In 77.3 per cent of these patients some gross evidence of coronary disease was found. In private civilian practice it has long been recognized that myocardial infarction and coronary artery disease in the age group under fifty occur predominantly in males. In older people this sex difference is much less pronounced. In patients under forty years, however, this difference is much greater. James and his

Dr. Roth. *Assistant Clinical Professor, Yale University School of Medicine, Department of Medicine; Associate Electrocardiographer, St. Raphael's Hospital, New Haven, Connecticut*

Miss Pepe. *Head Technician, Laboratory of St. Raphael's Hospital, New Haven, Connecticut*

SUMMARY

Twenty patients between the ages of thirty-two and forty years who had suffered from myocardial infarction due to atherosclerotic coronary artery disease were observed from 1947 to 1955. All patients are alive and have survived a total of sixty-one patient years. All were males, and all showed excellent functional recovery. Sixteen have returned to their previous or somewhat easier work. The incidence of coronary artery disease has increased in general and in young males particularly. Chest pain in young males therefore should be recognized as a possible indication of coronary artery disease. Factors of possible importance noted in this series of patients were nervousness, stocky build, overweight, heavy smoking, a family history of coronary artery disease, increased blood cholesterol or uric acid, and a decreased blood iodine or basal metabolic rate.

associates⁴ in a study of 147 proven infarcts in women report that their average age at the time of infarction was 64 years. Only five women had their infarction before the age of forty. All of these five patients had illnesses, such as rheumatic heart disease with auricular fibrillation, diabetes, thyroid disease, hypertension, polycythemia vera, all of which are known to predispose to myocardial infarction and thereby to reduce the difference between the occurrence rate of myocardial infarction in young males and that in young females. If none of these illnesses is present, myocardial infarction in people under forty years of age is almost exclusively an illness of males. This fact is also borne out by the findings of

From the Cardiac Section of St. Raphael's Hospital and Grace-New Haven Community Hospital, New Haven, Connecticut

Gertler and White⁵ and by this report of twenty patients under forty years of age.

MATERIAL

These twenty patients were all white males ranging in age from thirty-two or forty years. They were all personally examined and observed and their clinical diagnoses were firmly established by a characteristic history, by their clinical picture including increased sedimentation time, fever, and leukocytosis; and by characteristic electrocardiographic findings. Particular effort was made to exclude cases of benign pericarditis. The first of these twenty patients was seen in 1947; the last one was discharged from the hospital late in 1955. Most of them were private patients seen at the Hospital of St. Raphael, Grace-New Haven Community Hospital or in their homes; only a few were seen on the ward.

CLINICAL FINDINGS AND COMMENTS

Twenty male patients between the ages of thirty two and forty who had suffered from myocardial infarction have been seen by us since 1947. One of these had two attacks, an anterior and posterior wall myocardial infarction; the others had one infarction. Nineteen of the twenty were laborers or craftsmen, one was a white collar worker. As our private practice contains the usual cross section of white collar workers, laborers or craftsmen, the predominance of laborers in the young patient group seems to suggest that myocardial infarction, at least in this small series, is more common in young male laborers. These findings are in contrast to Gertler and White's^{5a} report on 97 young male patients with myocardial infarction. These authors found 53 patients in the professional or managerial group. Fourteen of our twenty patients were heavy smokers, using between 40 and 100 cigarettes daily. Four were moderate smokers, consuming 10 to 20 cigarettes daily, and only two did not smoke. This is a higher number of heavy smokers than one would normally find in a corresponding group of young males chosen at random. It is of interest to note that eleven of the smokers have given up tobacco completely. The alcohol intake did not seem to be unusual in this group. Only three were heavy drinkers. The histories indicated that coronary artery disease or other vascular disease was present in the families of ten of these patients.

A study of the uric acid, cholesterol, blood iodine, and basal metabolic rate showed that in the majority of these patients there was an increase in

cholesterol and uric acid, and a decrease of basal metabolic rate or blood iodine similar to those findings reported by Gertler and White.^{5b}

Seventeen of the twenty patients were overweight and nine showed a considerable growth of hair, particularly on their chest and fingers. They were, however, moderately bald and slightly grey. Prior to their attack only two of these patients showed hypertension, which improved greatly after their attack. None showed thyroid disease, diabetes, rheumatic heart disease, polycythemia, or familial hypercholesterolemia. Two had xanthelasma of the eyelids. Arcus senilis was present in four. Seven had anterior infarcts, thirteen had posterior infarcts. One had an anterior infarct and when seen a year later the electrocardiogram also showed definite signs of a posterior wall myocardial infarction. His history revealed that he had had chest pain lasting for several hours following the strenuous work of cutting down a tree. He did not report his illness nor did he go to bed, but continued his work as a salesman. Eleven patients had their initial attack without warning; nine had experienced angina pectoris on effort from one week to nine years prior to their myocardial infarction. In nine the attack came on while they were doing unusual work; in two of them while they were doing their usual work. In the nine remaining ones the attack occurred while they were at rest, six in bed, three while resting in a chair watching television or eating.

None of these twenty patients died despite the fact that one developed cardiac failure and two had thrombophlebitis, one with a pulmonary infarct. It is of interest to note that these thrombo-embolic complications occurred despite anticoagulant therapy. There were two cases of atrial fibrillation during the convalescent period. All of these patients received the same kind of treatment as have our older patients with myocardial infarction. Nine were treated with anticoagulants, eleven without anticoagulants. Among our older patients treated similarly, however, the mortality rate was the usual high one seen in older people with myocardial infarction. Absence of any fatality in this group of young patients with myocardial infarction seems therefore to indicate that young patients, as a group, have a better chance of surviving their attack than older ones, but it is recommended that the number reported here is too small to justify conclusions. The total survival time of all twenty patients is now 61 patient years. We are aware of the fact that in the

course of time we will encounter some fatalities even in younger patients with myocardial infarction and that some young men probably die of it before medical assistance can be summoned.

A fact of importance is that sixteen of these twenty patients did return to work, either to their usual work or to a somewhat lighter job, despite the fact that the great majority of them were laborers. They returned to work after an average of two to three months. One took four months, one six, and one nine months. These last three patients were physically able to return to work earlier but were afraid of doing so and needed a great deal of reassurance. Of the four who did not return to work, one had his attack only two months before this report was written, the second has an orthopedic disability which occurred shortly after his myocardial infarction, the third is engaged in a rehabilitation course to learn tool designing, and the fourth has an anxiety neurosis which prevents him from doing any work despite the fact that he is physically able. Nine of these twenty patients have no symptoms whatsoever, despite the fact that the electrocardiogram still shows residual signs in all but one. The remaining eleven have brief chest pain and retrosternal oppression on effort. Among these are two whose electrocardiograms have become normal.

The functional recovery of all these patients was quite remarkable, as the case report of one of them at the end of this paper so well illustrates. One patient (Case No. 2) was particularly interesting from a legal point of view as his myocardial infarction occurred during his work while he was doing something unusually strenuous. It was recognized by the Workmen's Compensation Commissioner as being caused by his work and the insurance company was ordered to pay full compensation for his illness.

Seventeen of these patients showed extreme nervousness; two of them were nail biters. Since none of the patients was seen prior to their heart attacks, it is uncertain whether their nervousness was just as great before the myocardial infarction or was caused by worrying about it. Reassurance is very important in caring for any patient, but it is particularly necessary in dealing with young patients who have suffered from myocardial infarction. In addition to their panicky fear of death, they are also tortured by the worries of the young dependent family and its insecure financial future without a

working father. Reassurance that the patient not only will survive his attack, but will also be able to pursue a gainful occupation will help a great deal in adding mental peace to the physical rest which we believe is necessary for recovery from myocardial infarction. We have found it quite helpful to discuss the course of the illness with the young patient as soon as he has recovered from the initial shock and to reassure him that, if everything goes well, he will be able to resume slight activity in three or four weeks and that he has a very good chance of returning to work in two and a half to three months. Chair rest, as advised by Dr. Samuel Levine,⁶ was found to be helpful in giving them added confidence in their eventual recovery. Too long a rest period in young patients who have manifested good functional recovery and who do not show any signs of activity of their myocardial infarction neither improves the patient's recovery nor helps prevent future attacks. Unnecessarily prolonged rest actually lessens the patient's chances of ever resuming a gainful living. It helps to make him a cardiac cripple who is afraid of doing the slightest work. The absence of all work gives him more time to think about his condition and a vicious circle is created, as one of the patients in this series well illustrated. Complete reversal of the electrocardiogram to normal and complete absence of chest pain on strenuous effort should not be prerequisites for return to work.

On the other hand, if any young male complains of chest pain we should keep in mind that the incidence of coronary artery disease has increased, and we should be particularly suspicious (a) if the patient is tense, stocky, overweight, hairy, a heavy smoker, and has a family history of coronary artery disease; (b) if there is an increased blood cholesterol and uric acid, and a decreased blood iodine or basal metabolic rate.

Avoidance of unusually heavy exercise, an excessive intake of fat, and heavy smoking may be helpful in preventing or at least postponing myocardial infarction. The future will show whether revascularization as advised by Thompson,⁷ Beck,⁸ and Vineberg⁹ will prevent the occurrence of myocardial infarction in such patients with angina or, if they have already suffered from an infarction, will help to prevent another one.

CASE NO. 1—F. S.

A bread salesman, 33 years of age, was playing baseball in December, 1954, when he became nauseated and had pain

in both arms with a slight pressure in his chest. Up to that time he had been perfectly well and had never experienced any chest pain, unusual tiredness, nor pain in his arms or neck. He was able to walk several miles a day without difficulty and went hunting frequently.

Past history revealed that patient was hospitalized at a Naval Hospital for nervousness during World War II. The family history was negative for cardiovascular illnesses. The patient smoked 60 cigarettes daily and took alcohol occasionally.

He was admitted to the hospital. The electrocardiogram showed changes characteristic of acute posterior infarction and occasional ventricular extrasystoles. He was stocky without signs of xanthelasma. Arcus senilis was absent. Hair growth was normal. Blood pressure was 100/80. Heart sounds were distant. No signs of heart failure were present. Sedimentation time was elevated. White blood count was elevated and there was fever on the second day. Treatment included bed rest, oxygen, and anticoagulants. He was discharged after three weeks with the advice to rest, to refrain from smoking, and to adhere to a low fat, low caloric diet. Three weeks later he was feeling very well. When asked if he had rested he answered that he had a wonderful rest in Canada, where he had been deer hunting! He was happy that he had downed the deer and was glad that he had proved to himself that he could go hunting just three weeks after his infarct despite the cold winter weather.

Examination at this time still showed signs of an old posterior wall myocardial infarct. The heart was not enlarged. Rhythm was regular with the exception of rare ventricular extrasystoles. He was advised to continue on a low fat, low caloric diet and to return to work. Ten months after his infarct he was seen again. He was free of pain. He was working without loss of time as a bread salesman. The electrocardiogram still showed signs of an old posterior wall infarction.

CASE NO. 2—E. D.

A truck driver, 38 years of age, was driving his high trailer truck filled with sand in October, 1954. He pulled himself up with one arm and tried with the other arm to block a leak in the gate with a piece of wood. While doing so, he experienced a severe pain in his left shoulder which he believed was due to injury of his arm. He continued his trip and when sand began to leak again he attempted once more to stop it. While he was doing this work, he experienced the same type of severe pain in his left shoulder but this time there was also pressure across the chest and a cold sweat. This pain persisted even after he had returned to the driver's seat. He was able to finish the trip but the pain became worse. He saw his family physician who referred him to St. Raphael's Hospital with a diagnosis of coronary thrombosis.

Inquiry revealed that he had been having pressure in his chest on any effort for the last nine years. This pain always subsided when he stopped the effort. He smoked 30 cigarettes and two cigars daily; he drank beer occasionally. His mother died of a cerebral hemorrhage and his father of coronary thrombosis. His mother and brother had diabetes.

The patient was a stocky, obese young man, 5 feet 11 inches tall, and weighing 215 pounds. His blood pressure was 100/70. There was no arcus senilis. Xanthelasma or tendon nodules were not seen. The examination was otherwise negative except for distant heart sounds. No signs of cardiac failure were present. His temperature became elevated on the second day. Sedimentation rate: 33 mm. in one hour. White blood count: 13,000. Blood cholesterol was elevated to 452 mg. per cent. Cholesterol esters were 242 mg. per cent. Blood iodine was decreased to 3.18 gamma per cent. Uric acid was elevated to 7.6 mg. per cent. Fasting blood sugar was 120 mg. per cent. An electrocardiogram showed the signs of acute posterior wall myocardial infarction. On fluoroscopic examination, slight rounding of the left ventricle with a large peri-apical fat pad was seen.

Eight weeks after the initial attack he was feeling well. He had no difficulty in breathing but had experienced once or twice a brief pressure in the chest on effort. In view of the connection between the onset of pain and the unusual effort, patient claimed and received workmen's compensation for his myocardial infarction. Since then he has been doing fairly well but he had to discontinue driving a truck. One year after the attack, in October 1955, he was feeling well and had only slight chest pain on fast walking. Physical and fluoroscopic examination of the heart did not reveal any abnormality. The electrocardiogram still showed signs of old myocardial infarction. The patient is engaged in a course for tool designing provided by the Connecticut State Rehabilitation Board.

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AN OBSTETRICIAN LOOKS AT PREGNANCY WASTAGE

HERBERT THOMAS, M.D., *New Haven*

THE association of pregnancy with the possibility of disaster for the mother and her unborn child must have occupied the thinking of early man almost from the time of his awareness of his own being. As in primitive society today, for him the phenomena of childbirth would be one of complete mystery, the supposed influences of good and evil spirits having a high place in his speculation. Death of the fetus in utero with expulsion, particularly when associated with gross abnormalities would but confirm for him some outside malign intervention. Among enlightened people almost down to our own day the forces of evil were seen in such manifestations although Aristotle, and later Galen, refuted such ideas. This attitude found wide expression in medieval literature and even in architecture. Many gargoyles bear a striking resemblance to certain types of fetal monstrosity. Deep in the texture of our own culture are sayings and superstitions which relate to the abnormal manifestations of pregnancy. Every obstetrician is aware of this bondage of superstition in many women of low intellectual caliber and indeed in some whose mental equipment is not so limited.

ABNORMAL SPERM AND OVA

A good deal is known today about causes of pregnancy wastage but much remains to be discovered. Some causal factors in pregnancy wastage no doubt antedate that event for it is likely that defective germ plasma plays a significant part. Thus, in the male the cycle from the spermatid or Sertoli cell to the mature spermatozoon requires about ten days. Some of the spermatozoa fail to develop normally and for this reason every specimen of sperm has some, if but a small number, abnormal forms. Whether these abnormal forms are capable of fertilizing and are the cause of abnormal conceptuses is not known. Neither is it known whether most of them perish early after formation.

The precise mechanism by which the ovum comes to maturity is still controversial but the formation

The Author. *Emeritus Professor of Obstetrics and Gynecology, Yale University School of Medicine*

SUMMARY

The factors producing pregnancy wastage are discussed beginning with the development of the germ plasma and continuing through the postpartum period. Multiple pregnancy, fetal monstrosities, and the fetal and maternal causes of abortion are mentioned. "The three great causes of maternal death associated with pregnancy," toxemia, hemorrhage and infection are listed and added to these are the various maternal diseases. Complications of labor and the puerperium add to pregnancy wastage.

Attention is called to the possibility of a solution to many of the problems concerned with pregnancy wastage if the public's interest can be aroused in supporting research in this field as it has in many other related fields of health.

of the graafian follicle and the extrusion of the ovum into the abdominal cavity is better understood. Although there is no such striking microscopic evidence of abnormal ova such as is seen in the instance of abnormal spermatozoa, it seems reasonable to believe that abnormality in either case could adversely affect pregnancy.

Multiple pregnancy is not normal in humans and it is accompanied by a higher incidence of pregnancy complications, such as toxemia, hemorrhage, and prolonged labor. In addition the majority of births are premature with increased hazards for the infants. These increased risks are more noticeable in the case of triplets or quadruplets.

Whatever may be the specific causes of fetal monstrosities there can be but little doubt that they are due in general to defects in early embryonal development. Congenital defects of minor degrees are not very rare, such as hare-lip, polydactylism,

From the Department of Obstetrics and Gynecology, Yale University School of Medicine

heart malformations, in which the causation no doubt is somewhat the same. Of great psychological importance is the fact that most fetal monsters die in the early weeks of pregnancy and for the woman end in spontaneous abortion. Fortunately, too, the majority of those that do survive and are delivered at term die within a few hours or days. Currently accepted theories regarding causation are faulty implantation of the ovum and faulty nutrition from poor blood supply. Certain contagions such as German measles occurring in the mother are responsible in some instances as will be commented upon later.

CAUSES OF ABORTION

In considering pregnancy wastage we differentiate between early and late abortions and premature labor. The term miscarriage is relegated to the lay vocabulary. The causes of abortion may be either fetal or maternal. Many years ago the anatomist Mall found that fifty per cent of fetuses expelled in spontaneous abortion were abnormal. More recently Hertig and Edmonds¹ found that ninety per cent of such fetuses presented anomalies considered to be incompatible with life continuance. Some of the better known causes of spontaneous abortion due to the fetus are diseases of the fetus and its membranes, defective placental development, and abnormal placental situation.

Among maternal causes of abortion are infectious disease, especially when accompanied with high fever, and disease of the uterus which may preclude proper placentation. Severe trauma may cause separation of the placenta to be followed by abortion. However, minor traumas, such as jarring, lifting heavy objects, and so forth are not likely to affect the well implanted placenta. Deficiency in hormonal balance is thought to be a potent cause of abortion and the claimed results from hormone administration in instances where abortion is threatened is considered by some to support this theory. Among paternal causes we find mentioned syphilis and possibly chronic alcoholism.

Certain infectious diseases of the mother may be the cause of fetal malformation. German measles occurring early in pregnancy may be so severe on the fetus as to make the likelihood of having a deformed child greater than having a normal one. The ravages of this disease have only recently become known to us and at present there are no legal grounds for the induction of abortion when it oc-

curs. The health of the mother is not usually seriously affected.

CAUSES OF MATERNAL DEATH AND INVALIDISM

The three great causes of maternal death associated with pregnancy are toxemia, hemorrhage and infection. The true toxemia of pregnancy is seen as a metabolic disturbance characterized by increased blood pressure, edema, and the appearance of albumin in the urine. Toxemic-like diseases which may simulate true toxemia are nephritis and nephrosis. In spite of our lack of knowledge of the cause or causes of pregnancy toxemia, the detection of its early stages and the inauguration of early treatment saves countless lives of mothers and infants each year.

Maternal diseases which may be associated with mortality in pregnancy are tuberculosis, poliomyelitis, diseases of the gastrointestinal tract, cardiovascular system, heart disease, blood diseases, diabetes. Surgical complications may include appendicitis, gall-bladder disease, cancer, ovarian disease, uterine fibroids and those peculiar to pregnancy as rupture of the uterus, and placental displacements.

To these pregnancy complications must be added the complications of labor and the postpartum period. It is in labor and the postpartum period that two of the three chief causes of maternal death are most often encountered, hemorrhage and infection. Abnormal bleeding during labor may cause fetal death or through fetal anoxia cause deleterious effects. According to Eastman and DeLeon,² "The opinion is growing that anoxia, consequent upon varying degrees of placental separation is an important, if not the most important, cause of cerebral palsy."

Many pregnancy complications lead to the birth of a premature infant with the hazards attendant upon premature existence. However, the care of the premature infant has today made great strides and infants are now saved that would have been lost a decade ago.

Pregnancy wastage for the mother is also seen in the aftermath of pregnancy, complications sometimes causing invalidism extending to months and years. Pregnancy wastage in this sense thus has vast implications. If we narrow the conception to immediate fetal and maternal mortality we find that (including for the fetus spontaneous abortions, conservatively estimated at 8 per cent of recognized pregnancies) for 1950, the astounding mortality of

363,145 deaths. Even this prodigious figure is percentage-wise low in comparison to that a generation ago. The reduction in maternal and fetal mortality in our own time through the efforts of doctors, nurses, public health workers, and others is a splendid record of achievement. The extension of regulated antenatal supervision as a part of good obstetrics has paid dividends in maternal and fetal salvage which no doubt represents our finest example of preventive medicine.

POSSIBILITIES FOR IMPROVEMENT

When we consider pregnancy wastage and what has already been done we realize that our present skills in pregnancy care are capable of far more service than is now offered. Dr. N. J. Eastman speaking of *Global Aspects of Midwifery* says, "Of the three great causes of maternal death, hemorrhage, infection, and toxemia, the majority of women now dying in economically underdeveloped countries could be saved by the application of just a few elementary principles of prenatal care and cleanliness. The instruction and training of traditional birth attendants should be part and parcel of the activity of any rural health unit in economically underdeveloped countries. This should be the main function in such areas for the fully trained midwife or nurse-midwife, who, as we envisage the picture, will be working as a part of a public health team under the supervision of an obstetrician and a public health official."³

If the public should become as excited about reproduction as it relates to human welfare in any such way as it now is in the attack on certain major diseases, benefits could accrue which would be of widest significance. The time could be ripe for such an awakening, for never before has the daily reading and other media of communication been so responsive to the general demand for information relating to human reproduction. Such subjects as pregnancy, marital relations, sterility, menstruation, menopause, breast feeding, are now discussed with a freedom never before existing.

Given a large public interest in supporting re-

search in reproduction and it is safe to predict that with the knowledge now at hand pointing the way, many problems concerned with pregnancy wastage would come to solution. The words of Dr. John Rock have significant meaning, "Yet consider our efforts to learn the nature and life history of the malignant cell, while we neglect the nature and life history of the fertilized egg and how it must be cared for by the mother that both she and her charge will prosper to substantiate the happy family."⁴

In our country the almost universal hospitalization of women for maternity care has been accompanied by a lowering of maternal and fetal mortality rates to figures not thought possible of attainment a generation ago. A step in advance too is seen in new procedures and new arrangements in obstetric and pediatric hospital care which show a recognition of the fact that a mother and her infant are not hospital "patients" in the usual sense but are having a normal life experience.

When it is more widely realized that the real start of family life begins with human conception and that its subsequent course can have better assurance of success through skillful and understanding care, wastages in terms of survival not only will be further eliminated, but wastages in terms of successful parenthood will be reduced. Wastages in human life incident to pregnancy should be considered in its broader meanings for it entails broader responsibilities on the part of those who give obstetric care than just those of safety to mother and infant. To the obstetrician this wider concept of pregnancy wastage offers a supreme challenge.

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THE CLINICAL ASPECTS AND DIAGNOSIS OF STEATORRHEA

ALLEN CHETRICK, M.D. and DAVID KATZ, M.D., *West Haven*

THE term steatorrhea was first used to describe the passage of liquid fat with stools. Today it has come to mean the passage of fluid or semifluid, pale, fatty and foul-smelling stools.¹ Yet this definition is limited because of the frequent occurrence of grossly normal appearing stools with high fat content. Diarrhea in the sense of frequency and fluid consistency of stools is usual but not the rule. Thus the presence of excessive fat in the stool is definitely established only after special laboratory examination of the stool. It is for this reason that Vachon² divides steatorrhea into the obvious group in which the fatty characteristics are constant and the less apparent group based on stool studies. These studies include microscopic examination of the stool with Sudan staining for visualization of fat cells and the quantitative measurement of fecal fat excretion.³ More indirect methods employed are based on

Dr. Chetrick. *Formerly Resident in Internal Medicine, VA Hospital, West Haven, Connecticut. Currently Research Fellow, American Heart Association, Yale University School of Medicine*
Dr. Katz. *Formerly Resident in Gastroenterology VA Hospital, West Haven, Connecticut. Currently Attending Physician, Mt. Sinai Hospital, New York City*

SUMMARY

Steatorrhea is often not recognized because it is usually not considered. Since the stools in steatorrhea may range in appearance from normal to foamy, frothy, foul-smelling stools, the diagnosis may of necessity have to be made by laboratory methods. The nature of symptomatology as a result of steatorrhea may be protean. Three patients seen in the West Haven VA Hospital over the past 18 months are presented. In two cases steatorrhea was not a bothersome complaint and was discovered only secondarily. All were greatly handicapped because of the metabolic defects caused by steatorrheas of different etiologies. Two responded well to therapy, but a third was refractory to therapy because of the chronic state of his illness. The various diagnostic aids in steatorrhea are reviewed. The management of steatorrhea in general and of the various specific conditions in particular is reviewed.

defective fat absorption and include fatty acid or chylomicron measurement after a fatty meal and vitamin A absorption curves.⁴

The causes of steatorrhea, formerly restricted to instances of deficient pancreatic secretion, are now known to be manifold. Therefore the importance of diagnosis for purposes of definitive therapy is obvious. Frazer¹ classifies these according to the absorptive defect: pancreatogenous, hepatogenous and enterogenous. A more simple division presented by Friedlander⁵ is that of primary or idiopathic

TABLE I

CAUSES OF STEATORRHEA

- I. Primary Steatorrhea
 - 1. Celiac disease
 - 2. Nontropical sprue
 - 3. Tropical sprue
- II. Secondary Steatorrhea
 - 1. Pancreatitis
 - 2. Fibrocystic disease of pancreas
 - 3. Biliary cirrhosis
 - 4. Obstructive biliary tract disease
 - 5. Postgastrectomy
 - 6. Post-small bowel resection
 - 7. Fistulas: gastrocolic, enterocolic
 - 8. Intestinal diverticula
 - 9. Regional enteritis
 - 10. Tuberculous enteritis
 - 11. Intestinal lipodystrophy
 - 12. Intestinal amyloidosis
 - 13. Intestinal scleroderma
 - 14. Intestinal neoplasia: lymphoma, sarcoma, carcinoma
 - 15. Intestinal giardiasis
 - 16. After oral antibiotics: sulfonamides, chloramphenicol and tetracycline drugs

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steatorrhea and secondary steatorrhea. Under the former heading are grouped celiac disease, nontropical sprue and tropical sprue, entities in which there is no demonstrable gastrointestinal lesion and whose pathogenesis is at present only conjectural. Under secondary steatorrhea are included the more usual entities of pancreatitis, fibrocystic disease of the pancreas, biliary cirrhosis or obstructive biliary tract lesions, regional enteritis, tuberculous enteritis, intestinal lipodystrophy and gastroenterocolic fistula (Table I).

The purpose of this paper is to present three recently observed cases of steatorrhea, a disorder which is probably more prevalent than recognized. Each case had a different etiology and each presented in a different manner.

CASE 1

A 48 year old gun stock worker noted the onset of diarrhea in May, 1954. He had previously been well. He noted that fatty foods would exacerbate the diarrhea. The stools were described as loose and foul smelling. They contained mucus and floated. He had never been out of the country. In the two months prior to admission the patient lost 35 pounds. He was admitted to the West Haven VA Hospital on June 17, 1954. There was no other outstanding symptomatology. Physical examination revealed a chronically ill man who showed evidence of recent weight loss. A grade III blowing systolic murmur was present, heard best in the fourth intercostal space 4 cms. to the left of the sternum. The heart was not enlarged and the cardiovascular examination was otherwise unremarkable. Abdominal examination revealed a liver edge palpable two to three finger breadths below the costal margin. Four-plus clubbing of the fingers and toes was noted. The remainder of the physical examination was normal. Laboratory findings were as follows: Hemoglobin 14 Gms. per cent, hematocrit 44 per cent, urinalysis negative. Blood urea nitrogen 10.6 mgs. per cent, chlorides 101 meq. per liter. Carbon dioxide combining power 24 meq. per liter. Serum amylase 82 units. Serum lipase 0.55 units, icterus index 4 units, serum bilirubin .65 mg. per cent, thymol turbidity 1 unit, BSP retention 4 per cent in 45 minutes, prothrombin time 36 per cent of normal, total proteins 6 Gms. per cent with an albumin-globulin ratio of 2.59/3.41. Other chemistries included calcium 8.3 mgs. per cent, inorganic phosphorus 3 mgs. per cent, alkaline phosphatase 13 B. U. An intravenous glucose tolerance curve was normal but an oral glucose tolerance curve was flat, the highest blood sugar level over a four hour period being 116 mgs. per cent one hour after ingestion of 100 Gms. of glucose. Stool cultures for acid fast bacilli and bacterial pathogens and febrile agglutinations were negative. Stool examinations for ova and parasites were negative, but frequent microscopic stool examinations revealed the presence of numerous fat globules and rare muscle fibers. On a measured 100 Gm. fat diet a 72 hour stool specimen revealed the fat content to be 68.3 per cent of the dry weight. Gastric analysis revealed achlorhydria with histamine

stimulation. A bone marrow examination showed erythroid hyperplasia with 13 per cent megaloblasts. Duodenal drainage obtained normal bicarbonate and enzyme levels after secretin stimulation. No *Giardia* were noted on duodenal drainage. A chest x-ray revealed calcified tuberculous lesions in both lung fields. A flat film of the abdomen revealed multiple calcifications of the liver and spleen. A small bowel series demonstrated a disturbed pattern (Figure 1) with involvement of the duodenum, jejunum and ileum. Segmentation, clumping and a moulage effect were noted.

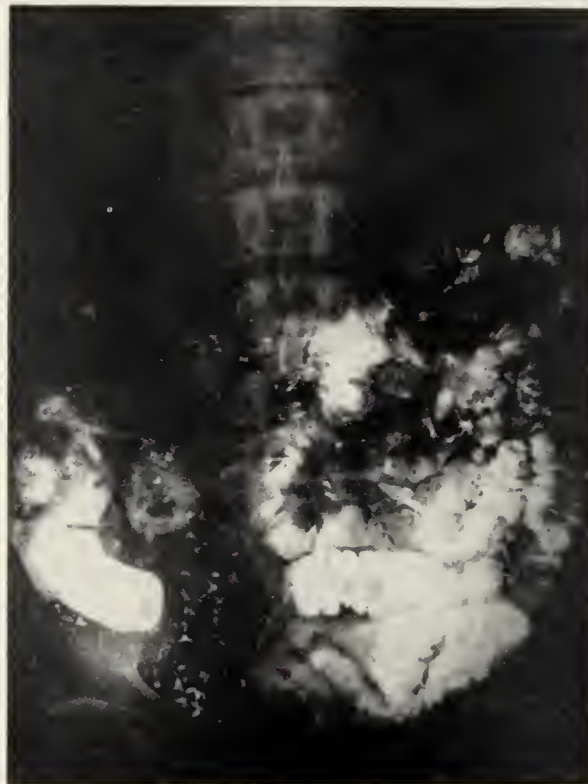


FIGURE 1 (CASE 1)

Disturbed small bowel pattern seen in case of nontropical sprue

The patient was started on a gluten-free, low fat diet with supplemental calcium and vitamin D orally and parenteral vitamin K and vitamin B₁₂. A rise in prothrombin time to 100 per cent was noted. A marked diminution in the size and smell of the stools was immediately observable. During the last month of his hospital stay he had one formed stool daily. The liver was no longer palpable on discharge. Blood values for calcium inorganic phosphorus and alkaline phosphatase returned to normal limits. The patient was discharged on September 5, 1954. Over the course of a year on the outlined regimen, the patient gained thirty pounds, worked and enjoyed excellent health. About October 1, 1955, the patient gradually became drowsy and disoriented. He was readmitted on November 22, 1955 to the West Haven VA Hospital in stupor. Despite an intensive diagnostic work-up, a satisfactory diagnosis was never made and

the patient died on November 30, 1955. It was considered that he had a viral encephalitis unrelated to the first admission.

AUTOPSY FINDINGS (CASE 1)

Gross: An interventricular septal defect was present. The pancreas and intestines were grossly normal. Numerous petechiae were noted in the white matter of the medulla, brain stem and cerebellum.

Microscopic: Sections through the intestines and pancreas revealed no pathology. Marked round cell infiltration of the meninges and gray matter of the brain, "consistent with encephalitis" was noted.

COMMENTARY (CASE 1)

This case must be considered as one of nontropical sprue. The presenting picture was that of diarrhea and malnutrition. The historical description of the stools was typical of obvious steatorrhea. This was confirmed by microscopic stool exams showing numerous fat globules and a 72 hour stool collection, 68 per cent of which was fat by dry weight (less than 25 per cent is considered normal). Additional studies consistent with the diagnosis of sprue syndrome were the small bowel deficiency pattern, the histamine-resistant achlorhydria, the flat oral glucose tolerance test, the bone marrow with significant megaloblasts and blood chemistries reflecting poor absorption of fat soluble vitamins K and D. These were the low prothrombin time, the low serum calcium and phosphorus and the elevated alkaline phosphatase. The response to therapy consisting of a gluten-free, low fat diet, parenteral vitamin K and B₁₂, and oral vitamin D and calcium in high dosage was dramatic. The steatorrhea disappeared; there was a weight gain; the liver was no longer palpable; and all abnormal chemistries reverted to normal. His death was untimely and unrelated to his sprue syndrome. Other diagnoses considered during life were tuberculous enteritis, Whipple's disease and pancreatic insufficiency. These were definitely excluded at postmortem examination.

CASE 2

A 67 year old retired pharmacist was admitted to the West Haven VA Hospital in March, 1954, because he had been feeling "run down" for three months. He had gradually lost an unspecified amount of weight and a private physician had diagnosed an anemia. Ten years previously he had undergone a subtotal gastrectomy for an obstructive duodenal ulcer at another hospital. He had no diarrhea or known steatorrhea prior to admission. Physical examination revealed an emaciated man weighing 87 pounds with bilateral pedal edema. There was a slight degree of cardiomegaly and rales were audible in the lower lung fields. There was evidence of peripheral arteriosclerosis. The remainder of the

physical examination was unremarkable. Laboratory studies included: hemoglobin 8.0 Gms. per cent, hematocrit 30 per cent, red blood corpuscles 2.9 million/cc., urinalysis negative and stools negative for occult blood. Blood indices and a peripheral smear suggested a hypochromic microcytic anemia. Electrophoretic studies of the serum proteins were normal. Total proteins were 5.4 with an albumin-globulin ratio of 2.6/2.8. All liver function tests were normal. Other chemistries were: Calcium 9.55 mgs. per cent, inorganic phosphorus 2.4 mg. per cent, alkaline phosphatase 12.7 BU. Achlorhydria even after histamine stimulation was noted. A gastrointestinal examination revealed only a functioning gastrojejunostomy. Barium enema was negative. Diffuse osteoporosis of the spine was noted by x-ray as were fractures of several ribs, the right scapula, the right zygoma and the left fifth metacarpal bone (Figure 2). The patient was started on a high protein, high calorie diet with oral calcium, iron and multi-vitamins. With correction of the anemia he gradually became edema free and was discharged on June 28, 1954. His hemoglobin had risen to 13.0 Gms. during three months of therapy. The anemia was ascribed to a deficiency in iron absorption secondary to gastrectomy.



FIGURE 2 (CASE 2)

Fracture of 5th left metacarpal bone

In September, 1954 he was readmitted because of convulsions. Since his discharge he had developed low back pain but was otherwise asymptomatic. He had maintained his weight. On the day of admission he suddenly convulsed for five minutes and was unconscious for several hours. Physical examination again revealed an emaciated man. No pedal

edema was noted. Neurological examination revealed weakness of the right arm and leg. Lumbar puncture and electroencephalographic examinations were negative. X-rays revealed new fractures of the right parietal bone (Figure 3) and right acetabulum, not previously present. Laboratory examinations revealed: Hemoglobin 12 Gms. per cent, hematocrit 42 per cent, urinalysis negative, blood urea nitrogen 22 mgs. per cent, calcium 8.9 mgs. per cent, inorganic phosphorus 3.15 mgs. per cent, alkaline phosphatase 13.45 BU, albumin-globulin ratio 3.2/2.8 and 24 hour urine calcium while on a controlled low calcium diet 18.1 mgs. It was considered that the convulsive episode was due to a thrombosis of the left anterior cerebral artery. On this admission a 72 hour stool collection revealed 33.5 per cent fat by dry weight. Testosterone and stilbesterol were added to the previous regimen and the patient was discharged after two weeks of hospitalization. He was readmitted on December 27, 1955. He had fallen two weeks prior to admission and because of back pain had remained in bed. He had lost five pounds since the previous admission. His weight was 75 lbs. Physical examination was essentially unchanged except for percussion tenderness over the spine and both hips. A chest x-ray revealed an increase in the linear rib fractures. There was also a severe compression fracture of D12 (Figure 4).

Laboratory results were as follows: Hemoglobin 13.8 Gms. per cent, hematocrit 44, albumin-globulin ratio 3.2/3.4,

calcium 8.9 mgs. 5, inorganic phosphorus 3.57 mgs. per cent, alkaline phosphatase 5.5 BU, normal oral and I V glucose tolerance curves and normal serum amylase and lipase levels. A 24 hour urine for calcium contained 36 mgs. Urinalysis revealed 3 plus albumin with varying numbers of WBC's in sediment. A urine culture was negative. Blood urea nitrogen was 31 mgs. per cent. A 72 hour stool collection contained 15 per cent of the intake as fat. The carmine red marker, used to note the beginning and the end of the collection passed through the patient in six hours. The patient was continued on a high protein, high calorie diet with 12 Gms. of supplemental calcium gluconate and 100,000 units of vitamin D daily added. High doses of testosterone and stilbesterol were also given. The patient's course was progressively downhill and he expired quietly on March 10, 1956.

AUTOPSY FINDINGS (CASE 2)

Gross: Extreme wasting was noted. The antrum and pylorus of the stomach had been removed at surgery. The gastrojejunostomy stoma and intestines were normal. The liver weighed 1250 Gms. The pancreas was normal. A thrombus occluded the left renal artery.

Microscopic: Sections through the gastrojejunostomy site, jejunum, ileum, colon and pancreas were normal. An arteriosclerotic plaque compromised the left renal artery. There was no evidence of acute or chronic pyelonephritis.



FIGURE 3 (CASE 2)
Linear fracture of the right parietal bone



FIGURE 4 (CASE 2)
Compression fracture of D12

COMMENTARY (CASE 2)

This is a case of osteomalacia secondary to post-gastrectomy steatorrhea.⁶ In this patient the only gastrointestinal lesion was a Billroth II anastomosis. The presenting features were anemia, edema and bone pain. Only after x-ray evidence of diffuse osteoporosis and multiple linear fractures was the patient investigated for a metabolic bone disease. Low serum calcium and phosphorus and an elevated alkaline phosphatase were found. The diagnosis of osteomalacia was thereby established. It is of interest that in England the most frequent complication of steatorrhea is osteomalacia.⁷ The underlying cause for osteomalacia in this case was felt to be a lack of vitamin D and calcium absorption secondary to postgastrectomy steatorrhea. Wollagter⁸ has demonstrated a higher lipid excretion in the stools after gastrectomy. The steatorrhea in this case was not apparent and discovered only after microscopic fat globules were seen in the stool and a quantitative 72 hour stool examination revealed the fat content to be 33.5 per cent of the dry weight. There was no evidence of calcium loss due to idiopathic hypercalcuria, renal acidosis nor hyperparathyroidism.⁹ The iron deficiency anemia originally found and corrected by ferrous sulfate was also presumed to be on a postgastrectomy basis. This case illustrates the importance of closer follow-up of gastrectomy patients to discover steatorrhea early and correct it by a Billroth I procedure or medical therapy. In this particular man there was a 10 year interval following his subtotal gastrectomy during which time there was no medical supervision. At the time of presentation to us he was too debilitated to consider surgery and the chronicity of his disease was medically irreversible.

CASE 3

A 63 year old white male carpenter was admitted to the Newington Veterans Administration Hospital in June, 1951 because of bilateral swelling of the legs of four months' duration. He had lost twenty pounds in the preceding eight months. Eight months prior to admission a severe anemia was detected at another hospital. The patient required transfusion of four units of blood. A gastrointestinal series was reported as negative at that time. His stools were grossly fatty on admission but were not otherwise described. Physical examination was not revealing except for bilateral pitting edema of the extremities and massive scrotal edema.

Laboratory results revealed the following: Hemoglobin 10.5 Gms. per cent, RBC 3.3 million per cc., urinalysis negative, serum amylase and serum lipase within normal limits, achlorhydria after histamine stimulation, total protein 6 Gms. per cent with albumin-globulin ratio of 2.6/3.4, normal intravenous glucose tolerance test, no rise of amylase

or lipase after intravenous secretin and morphine administration. A bone marrow was normal. A flat film of the abdomen revealed calcareous deposits within the duodenal loop. The edema disappeared after six days of bed rest. After three weeks of hospitalization the patient was given 10 Gms. of pancreatin three times a day. He reported that the oil had disappeared from his stool on this regimen. One thousand cc. of whole blood was given. The patient was discharged after eight weeks of hospitalization with instructions to continue the medication at home. He was on a high caloric diet. In December, 1952, after voluntary cessation of pancreatin one month previously, swelling of both lower extremities and the scrotum recurred. He was rehospitalized. Physical examination was similar to that of the previous admission and no hepatomegaly was noted. Laboratory workup revealed a hemoglobin of 11.5 Gms. per cent, RBC 3.4 million per cc. and initial urines containing albumin and varying amounts of white and red blood cells. Subsequent urines were negative. A PSP excretion of 55 per cent in one hour was noted. Blood urea nitrogen was 15 mgs. per cent. Other findings were: Total protein 4.8 Gms. per cent with an albumin-globulin ratio of 1.8/3.0, calcium 8.3 mgs. per cent, phosphorus 3.6 mgs. per cent and alkaline phosphatase 7.3 Bodansky units. The venous pressure and circulation time were within normal limits. On a regimen of sodium restriction and pancreatin the edema subsided and the patient lost twenty pounds within one week. The serum albumin rose to 2.8 Gms. per cent and the patient was discharged within a month on the hospital regimen.

The patient was admitted to the West Haven Veterans Administration Hospital for the first time on February 13, 1956. He had stopped taking pancreatin ten months prior to admission. Six weeks prior to admission he had once more noted swelling of his legs and scrotum. For the first time he noticed swelling of the abdomen and about the eyes during the week prior to admission. He had been having three to four bulky, greasy and occasionally foul smelling stools per day intermittently for weeks at a time since his discharge from Newington. He would usually awaken twice nightly during these episodes to go to stool. His appetite had been excellent, but his weight remained at 139 lbs. Prior to 1950 his average weight was 165 lbs.

Physical examination revealed an emaciated white male with anasarca. He had periorbital edema, bilateral pleural effusions, ascites, scrotal edema, sacral edema and bilateral pedal edema. Jugular venous distension was noted. No murmurs were audible. The skin over both lower extremities was indurated with mottled cyanotic hue. Laboratory results included: Hemoglobin 10.4 Gms. per cent, hematocrit 37 per cent, CO₂ combining power 26 meq. per liter, chlorides 110 meq. per liter, calcium 8.8 mgs. per cent, inorganic phosphorus 3.3 mgs. per cent, alkaline phosphatase 7.1 Bodansky units, cholesterol 78 Gms. per cent, total proteins 5.24 Gms. per cent with albumin-globulin ratio of 1.82/3.42, prothrombin time 66 per cent and achlorhydria after histamine stimulation. An oral glucose tolerance test revealed a diabetic curve with a two-hour level of 324 mgs. per cent and return to normal level at four hours. Initial urinalysis revealed no albumin and varying amounts of casts and cellular elements but these cleared with time. A 24 hour urine specimen was reported as containing no albumin. PSP revealed 60 per cent excretion in two hours.

BSP was reported as 4.5 per cent retention in 45 minutes. Stools consistently showed fat droplets and muscle fibers on microscopic examination. While on a controlled 100 Gm. daily fat intake a 72 hour stool examination revealed fat as 72.5 per cent and nitrogen as 11.9 per cent of the dry weight of the stool. Other studies included cephalin flocculation 0 in 48 hours, prothrombin time 66 per cent, radioactive iodine uptake 21.2 per cent in 48 hours, normal bone marrow, normal muscle and skin biopsies and negative LE preparations. A gastrointestinal series (Figure 5) revealed pancreatic calcification. An intravenous pyelogram was interpreted as showing pyelonephritis of the right kidney.



FIGURE 5

Calcification in the head of the pancreas is illustrated by arrow

On a low sodium regimen and bed rest the patient lost 18 pounds in 13 days. He was again put on a low fat, high protein diet and pancreatin 15 Gms. per day in divided doses. Almost immediately stools decreased to one or two daily and were noted to be smaller and less foul. After 17 days of pancreatin therapy no edema was noted and the patient has regained twenty pounds. The serum albumin has risen slightly to 2.5 Gm. per cent. The anemia, however, has remained refractory to parenteral vitamin B₁₂, liver extract and ferrous sulfate at the time of this writing.

COMMENTARY (CASE 3)

This case can now definitely be considered as one of pancreatic insufficiency. The initial picture of

anasarca, anemia and the urinary findings on several occasions, however, did raise the possibility of the nephrotic stage of glomerulonephritis. It was only after the discovery of extensive pancreatic calcification that the additional history of frequent oily stools was elicited. Subsequent stool studies revealed numerous fat globules and muscle fibers on microscopic stool examinations. Impaired fat and protein absorption was further substantiated by a 72 hour stool collection in which the dry weight of the stool was 72.5 per cent fat and 11.9 per cent nitrogen. Hypoalbuminemia was therefore ascribed to poor protein absorption due to pancreatic insufficiency rather than hepatic insufficiency. This was further supported by the low blood levels of pancreatic enzymes after secretin stimulation and the diabetic type oral glucose tolerance curve. Also the other liver function tests were within normal limits. It is felt that a concomitant renal lesion is undoubtedly present, but studies would indicate that this is not the cause of hypoalbuminemia. The hypoalbuminemia is felt to be the primary cause of the past edema.¹⁰ The final point of interest in this case is the response to pancreatin. Stool frequency and characteristics have been completely changed. At present only a few fat cells and a rare muscle fiber have been seen in stools microscopically. There has been a 20 pound weight gain, the edema has disappeared and the serum albumin is beginning to rise. The anemia has thus far been refractory.

DISCUSSION

It becomes obvious from a review of the cases presented that the recognition of steatorrhea is delayed because it is not considered. The practitioner in temperate climates too often considers steatorrhea as a tropical disease only. It is now known, however, that many conditions can simulate the sprue syndrome. Therefore, once steatorrhea is established the difficult task of determining the underlying disorder remains. The primary rule in history taking is that of keeping the possibility of steatorrhea in mind. A classical story of large, foul-smelling, frothy stools can frequently be obtained, but in a significant number of cases the steatorrhea is not grossly recognized or is transient depending upon fat intake. Information as to whether the stool floats or discolors the toilet bowl after flushing is suggestive. A history of return from a tropical climate may be helpful. On occasion the patient may recognize the flare-up of symptoms with specific foods.

Mothers frequently note this in children with steatorrhea due to celiac disease. A history of previous pain in the abdomen recalling pancreatitis or of a surgical procedure may suggest a secondary cause. The presenting complaint, however, is often related to a complication of the steatorrhea process. Since the absorption impairment can result in a variety of deficiencies the initial history may be that of weight loss, edema, skin disease, increased bleeding tendency, fatigue, pallor, bone pain, inflamed tongue or nervous system symptomatology.

Physical examination will aid in demonstrating the various facets of the absorptive defect. Emaciation and anemia of various degrees may be noted. Edema due to deficient serum albumin may be striking. Skin changes will often be present. Purpuric areas may be seen. Xerophthalmia, cheilosis and glossitis may suggest vitamin deficiencies. Combined system disease may exist with its signs.¹² Basic laboratory studies will frequently demonstrate abnormalities. Stools may grossly appear like homogenized peanut butter when smeared out. They should be examined in all suspicious cases for muscle fibers and fat globules after Sudan III staining. Defective fat absorption may cause low prothrombin levels, low calcium and phosphorus levels and where osteomalacia is a feature, a high alkaline phosphatase is present. A macrocytic or microcytic hypochromic anemia may be found. There may be low serum protein levels with reversal of the A/G ratio. Liver function will often manifest the extent of the disease process. Disturbances in electrolyte balance may occur during episodes of severe diarrhea. Of the special studies available, those concerned with fat absorption and excretion are most essential in establishing a diagnosis of steatorrhea. With patients on controlled intakes of 100 Gms. of fat per day, stools are collected over a 72 hour period. Stool fats are determined and reported as either: (1) the coefficient of excretion which is the fraction of fat excreted over that ingested; or (2) the percentage fat of the stool dry weight. The normal coefficient of excretion is approximately 5 per cent; the normal percentage of total fat per dry weight in stool is 7 to 27 per cent. Due to daily variations some observers have suggested repeated examinations over a nine or twelve day period. Unfortunately this quantitative study is not done in the ordinary laboratory. In an effort to do away with stool determinations various absorption and tolerance tests have been proposed. Among these are the measurement

of serum total fats postprandially, chylomicron studies, blood carotene levels, vitamin A tolerance tests and radioactive-iodine-labelled fat uptake studies.¹³ None of these examinations is specific for a certain type of steatorrhea but all may suggest the presence of an absorptive defect.

In an attempt to differentiate between enterogenous and pancreatogenous forms of steatorrhea the glucose tolerance test is of aid. In the former a flat, oral glucose tolerance test is usually found due to impaired absorption of glucose. In the latter form an oral or intravenous test shows impaired glucose utilization due to insulin deficiency. Duodenal drainage to evaluate pancreatic and biliary function has been utilized in an attempt to determine the cause of steatorrhea.¹⁴ Pancreatic enzymes after secretin stimulation can be determined. Biliary crystalluria may suggest biliary stone. Cytology may establish a diagnosis of neoplasm. Roentgenographic studies may be of aid in the differential diagnosis of primary and secondary steatorrhea. The former will be characterized only by the so-called deficiency pattern with disturbed mobility and alterations of pattern.¹⁵ Areas of constriction and dilatation of a constant nature may suggest a specific organic process such as regional enteritis. A previously unsuspected surgical procedure or a gastrocolic fistula may be revealed by roentgenography to be the cause of symptomatology. The occasional rare disease such as jejunal diverticula may be noted as the cause.¹⁶ Pancreatic lithiasis may be demonstrable. On occasion diagnosis may only be possible by laparotomy or biopsy obtained at surgery.

Specific therapy may be directed toward most of the causes of steatorrhea. Indeed in chronic pancreatitis the utilization of 5 to 10 Gms. of pancreatin per day may be used as a diagnostic test with a good response implicating pancreatic deficiency as the cause of steatorrhea. Surgery may be necessary to revise previous surgical procedures.¹⁷ The Billroth II anastomosis may be changed to a Billroth I gastroduodenostomy. The latter procedure limits the degree of fat loss. Blind loop enterostomies created by end-to-side anastomosis of bowel may be recreated as end-to-end procedures. A gastrojejuno-colic or gastrocolic fistula should be repaired. Biliary tract disease may be remedied by surgical approach.

Tropical sprue, a form of idiopathic steatorrhea, will usually respond to folic acid, 30-50 mgs. daily. Liver extract may also be used.^{18,19} Nontropical sprue will frequently respond to a gluten-free diet.

This necessitates the elimination of wheat and rye. Cortisone or ACTH will usually be effective in those patients with nontropical sprue where diet is ineffective.²⁰ A diet low in fat, although not specific, will help control the symptomatology of steatorrhea. Paradoxically it has been shown that as the fat in the diet is increased, patients with steatorrhea have more symptoms but absorb more fat. Consequently, increasing dietary fat will also increase caloric intake despite the large bulky stools. On low fat diets fat levels up to 70 per cent will be excreted. At high levels only 30 per cent may be excreted. A diet of 100 Gms. of fat with high protein intake should be assayed. In those conditions necessitating a gluten-free regimen certain carbohydrates will of necessity be curtailed. Because of the wide spectrum of materials poorly absorbed or lost because of the steatorrhea, various supplements must be added. Iron, vitamin B₁₂, folic acid or liver extract will combat the microcytic or macrocytic anemias or their combinations. Intravenous iron therapy or cortisone may be necessary on occasion.²¹ Vitamin A and vitamin K, both fat soluble vitamins, usually need to be supplemented. Vitamin D and calcium in high dosage may also be necessary, particularly in those cases where there is osteomalacia or low calcium levels leading to tetany. The vitamin B complex will combat a Wernicke's type picture. Electrolytes must be added if diarrhea has caused depletions.

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MEDICINE IN A CHANGING WORLD

DAVID B. ALLMAN, M.D., *Atlantic City, N. J.*

The Author. *Trustee, American Medical Association; Senior Consulting Surgeon, Atlantic City Hospital, Atlantic City, N. J.*

SUMMARY

The theme of this address is that not only as physicians but as members of society we must acknowledge that change is constantly taking place in life and that, therefore, we must recognize this fact and meet each change as it occurs with all our energies. The author reviews many of the outstanding changes we have witnessed in the last fifty years. Emphasis is placed on the struggle taking place between the philosophy of the material and the philosophy of the spiritual ideal. We are tempted to give up personal responsibility and individual initiative and relinquish to other agencies, especially those of government, the responsibilities which should be ours. Because we are in danger of becoming weak and effete, we in America need a new revolution in the literal sense of the word.

The author calls upon the medical profession to resist the growing tendency to materialism and through unselfish service and high-souled fulfillment to be good physicians and good citizens.

come before. There is scarcely an aspect of life which has not been profoundly affected.

Consider the sphere of food alone. The fundamental processes of food raising, cultivation, preservation, and preparation, whether we consider the production of vegetables and fruits or of meats, have undergone radical changes based upon new scientific knowledge applied to plant feeding, crop rotation, irrigation, and mechanization; cattle feeding, transportation, butchering, packing, refrigerating, and canning, cooking, and serving. We enjoy today, as the ordinary accommodations of our tables, viands which in variety and excellence were simply undreamed of, impossible luxuries fifty years ago.

IN considering what I might discuss here with you today, I knew that the subject of my choice should be one of sufficient importance and of sufficient appropriateness to merit your time and attention. It should, I felt, be significant for you and me not only as doctors but as citizens of the world of today. Ultimately I settled upon "Medicine In a Changing World," because I am convinced that the determining factor for survival, as for success, is the ability to adjust to the changing conditions of life, and to overcome them, rather than be overcome by them.

The challenge of life, it seems to me, is change, change which is fraught with peril for those who cannot meet it, but is merely a prologue to new triumph for those who are sufficiently adaptable and resilient to adjust to it.

There can be no growth without change, as there can be no decay. There can be no standing still, either. Change is inseparable from life, and its reverberations seem palely to carry even beyond the frontiers of death. So we must acknowledge the constancy of change, confront each new change as it comes along, and bend our energies to meeting and besting it. That is our challenge today as members of society, and it is no less our challenge as members of the profession of medicine.

It is not, then, in the fact that changes have occurred and are occurring that our times are remarkable; for as the poet says:

"Each age is a dream that is dying
Or one that is coming to birth!"

But our times are remarkable, if they are not unique, for the extensiveness of the range of changes which have taken place and are taking place, and the swiftness with which these changes follow one another.

Within a half century, a period of time to which many of us have been eye witnesses, such a multiplicity of changes has taken place as seem to me to outstrip the sum of all the changes which have

Presented at the annual meeting of the Connecticut State Medical Society, Hamden, April 25, 1956

January, 1957

There has been, truly, a happy conspiracy of improvement and progress. Properly basic to this progress and chiefly responsible for it have been scientific inventions and scientific production methods. We have utilized water, air, electricity, coal, fuel oils, and natural and artificial gases to operate the countless new engines and mechanical wonders which add to our ease and comfort. Now we are well on the way to the control and utilization of atomic energy!

Within the memory of living men the gasoline internal combustion engine, the turbine engine, the diesel, the turbo-jet, and the jet have all added their power to the dreams of men, to make even the most fantastic and ambitious of those dreams come true. The automobile alone has made a contribution to the physical, social, and economic growth of our country sufficient to make this age forever memorable. It has really made us, in a physical sense, the United States of America; for by the network of roads which it has necessitated, it has practically eliminated distances which isolate and insulate and has brought us all, physically at least, nearer as neighbors.

Railroads and airplanes have completed the conquest of distances until today we live in a world of physical intimacy, because the modes of travel have shrunk the severing wastelands and have bridged even the broadest oceans. This is change indeed, making us accessible to foe as to friend, and confronting us with new problems in consequence.

Turn where you may, the story is the same. There have been growth and improvement in every aspect of our material life. Incredible machines decrease man's industrial burdens, but by their productions so increase the national wealth as to afford the worker better standards of living and higher income, though progressively lightening his work load.

In his home the average citizen of moderate means today is served by machines as hitherto no person of wealth was ever served by domestic help. Machines keep his home cool in summer and warm in winter; they warm his water for bathing and cool it for drinking; they cook meals, wash and dry dishes, launder clothes, give him the news of the day, and supply entertainment and instruction by both audible and visible means. By means of electric eyes and closed circuit shortwave radio nursery-units, today machines even mind the baby. About the only things machines do not do for us is beget

and bear our children, and we are still too set in our ways, and pleased with them, to want them to do that.

Changes in the sphere of medical and surgical care and treatment have been little short of miraculous.

There was a time, and that not long ago, when the members of the medical profession, in America as in the rest of the world, stood in appalling helplessness before the powers of disease and death. The potent processes of infection and debilitation were little understood and ineffectually resisted. Indeed, the basic processes necessary for the maintenance of healthy living were only hazily guessed at. Then, bit by bit, in an atmosphere of anguished hopes and earnest strivings, the balance of power shifted. Step by step the science of medicine expanded; our knowledge of the true causes of disease conditions increased; and methods were discovered and techniques evolved in every department of professional endeavor which have enabled us to enter into the homes and lives of our fellowmen with the gifts of healing and of health.

The magnificent consequences are familiar to us all. No longer need man creep through life in the oppressive and baleful shadows of disease and death. Now with buoyant step, in the full sunshine of vigorous, protected health, he can stride along the road of life, free from fear and pain as in all time he was never free before.

These are changes which medicine has brought about, good changes for which we can and should all be universally grateful: to man, for his unselfish genius and industry; and to God, for His loving providence.

Relatively few are the diseases that continue to defy us. The shock troops of science are vigorously assaulting the gates of the fortresses of disease which still hold out. If man were not by nature doomed to die, science might even aspire to an eternal triumph. As it is, the average human's life span has become so lengthened as to pose other new problems such as men have never been called upon to deal with before.

In view of all these accomplishments, one might expect that these would be halcyon days of honor and attainment for the men and women of medicine and of widespread satisfaction to all. But to our sorrow we know that such is not the case. Despite the immense benefits which the doctors of today can confer, benefits ranging widely beyond the most

rosy dreams of the doctors of other generations, the doctor's place in society, and in the hearts of his fellowmen, is less honored and less secure than it was when he had fewer benefits to bestow. This is because of other changes which have occurred and are taking place, changes socio-economic in character, changes which we must recognize and deal with for our own good and for the good of society of our day.

Whether we realize it or not, we all entertain basic philosophic concepts which become the principles of action by which we live. For most of us these concepts are not the results of our original thinking. We adopt them from more vigorously thoughtful men who are, by natural abilities, leaders of thought and of action. Such men wield great influence for good or for evil over the destiny of a nation and its people. We were fortunate in the United States of America that in the days of our beginnings and of our early growth we had high-souled and high-minded articulate leaders who made popular conceptions and principles the most wholesome and the most noble that have ever inspired a nation.

Our founding fathers helped us to realize that for the good of all, the rights of the individual in any free society must always be preserved inviolate against invasion. They led us to disapprove, and actively to resist as tyrannical, government not based upon the consent of the governed. They made us understand that liberty is the most desirable state for man, enabling him to direct the course of his own life in the pursuit of his personal happiness. And, as a corollary to the concept of individual liberty, they developed an appreciation of the necessity of a spirit of independence and self reliance. Then they insured this spirit of freedom and independence against deterioration into lawlessness and anarchy, by inculcating the concept of the brotherhood of men under the fatherhood of God.

Love was the leaven which they employed to make certain that the searchings and seekings of vigorously free and independent people would not degenerate into a conflict of selfish desires, but would consolidate into a national strength and a national greatness exemplifying the tranquility of right order. They united our citizens in a dedicated bond of brotherhood and gave to us and to the world a new nation, of unprecedented strength and unrivaled greatness.

Love of liberty, responsibility, self reliance, in-

dustry, and resourcefulness, these were the traits typical of American citizens. Because of them our country grew and prospered. No obstacle was too great, no barrier too broad for the zest of free men, determined by their own strength to achieve security for themselves and for their beloved country. No competition was too keen, no threat too formidable for men and women dedicated to seek and achieve a fuller, freer life. Nothing was able to impede the sturdy march of America and Americans over the road of freedom to the heights of accomplishment and success, nothing, that is, until the corrupt concepts of materialism tainted the minds, contaminated the hearts, and enfeebled the spirits of men.

It was not in America only that the philosophy of materialism made successful inroads. After World War I, which made death, destruction, and privation almost universally familiar, weary men and women were ready for concepts that substituted superficial pleasure for substantial happiness, proximate riches for ultimate wealth, thrills for genuine satisfaction, sex for love, cleverness for wisdom, expediency for principle, and selfishness for sacrifice. Soon success came to be measured not in terms of what had been accomplished but of how little one had to do and how much one managed to get.

The essential drive of Americans remained, but now its character and direction had changed. No longer was it unselfish, moving outward from generous hearts and spirits determined to share their treasure; now it became selfish and narrowing, accepting fleeting material rewards at the cost of eternal spiritual values. In consequence, we learned the deep and bitter truth of Oliver Goldsmith's lines:

"Ill fares the land to hastening ills prey,
Where wealth accumulates and men decay."

The depression made clear how much had changed. Some Americans whose ancestors had spurned money for the freedom of living wondered if, their money gone, life was worth retaining. Others decided that the task of recovery was too much for them and sought means of bartering their freedom for security. But, thank God, not all so reacted! Some there were who learned that the things of material character which misfortune can sweep away are not essential to human life and happiness. These people found that, in adversity, love and loyalty and justice and truth remain unaffected, and in some instances grow deeper and

richer. Such people did not falter; taking heart they readressed themselves to the task of making a good living, knowing, what they had not known before, that the making of a good living is definitely secondary in importance to the making of a good life.

The struggle between the philosophy of the material and the philosophy of the spiritual ideal continues. Allegiances are still divided. Our ranks are split; therefore our strength is weak. Today we are a people torn between two influences: the influence of the past, of our traditions and lineage, moving us to exalt freedom, personal responsibility, and individual initiative; and the influence of the present, an influence of opportunism, moving us to get rather than to give, to prefer soft security to militant freedom, to want the laxness of personal irresponsibility, even when it means ceding to other agencies, especially of government, the responsibilities we should retain and discharge ourselves.

There is mounting evidence to show that we are in danger of becoming a weak and an effete people. We are manifesting alarming inclinations to sell our birthright for a mess of pottage. And the tragedy of it all is that deep down we retain the old undeniable and ineradicable appetites, which our forefathers knew were natural to all men. In consequence, if we ultimately get the mess of pottage, we will inevitably loathe it.

This is the changed and changing world which confronts us Americans today. Thus far the changes have been insidious and gradual, but they have been indicative of a progressive weakening of our national character that could not be more ill timed. A titan of tyranny is even now contending with us, and with all other free nations, for the dominance of the world. It typifies despotism and all that is contrary to our basic ideals and aspirations. It offers the irresponsibility of bondage for the responsibility of freedom. It exalts the rights of the state over the rights of the individual. It holds out material rewards or punishments as a substitute for spiritual satisfactions. Fear and pain and unrelenting oppressions and cruelties are its regular instruments of administration. It knows nothing of justice or charity. Thus slavery today stands toe to toe with freedom. Now is the time, therefore, when freedom must find full and effective vigor or accept the ignominy of defeat.

In the light of all these circumstances, it seems to me that what we Americans need most today is a new

revolution, a good revolution! I use the term in its literal sense. When anything revolves, it pivots through a full circle to return to its starting point. We Americans need to return to our starting point, to our early vigors of idealism and dedication. There is work to be done of such magnitude that each must do his full and conscientious best if we are to have a decent chance to win and to survive.

In these times every action of any citizen which further enfeebles himself or impairs our national strength is an act of treason. Selfishness, irresponsibility, indifference, opportunism, dishonesty, injustice, and anything else that makes for diminished individual work or lessens our common cooperation is a blow at the heart of our country today. We need a good revolution, a return to the true and lasting good as our fathers saw it and passed it on to us. As citizens and as doctors we must do all in our power to bring that revolution about.

The men and women of medicine have shown no greater immunity to the corruptions of the shortsighted materialism which grips the world than have any others. This is a time for all to reclaim the best of the past and to rededicate themselves to the best that the future can bring. By word and by action we should strive individually to show the way through unselfish service and high-souled fulfillment of our duties, back to the true character of the American citizen, which once we owned. The good that continues we must acknowledge and advance. The evil that exists, we must dig out and destroy, or else suffer it to destroy us.

The time calls for good doctors everywhere, and for good citizens. Nothing less will do. Our problems are great, therefore our strength must be great, also.

Our forefathers are remembered and revered for the effectiveness of their resistance to the tyranny which confronted them in their times. The tyranny of kings.

May we be likewise remembered by those who follow after us for having had sufficient vision to recognize the twofold tyranny of our times, the tyranny of soviet despotism that threatens from without, and the tyranny of selfish materialism that gnaws from within. May we be remembered not only because we had the vision to perceive the evil, but because we had the courage, the high valor, effectively to resist it!

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

1957

Traditionally the arrival of the New Year signals a time for new resolutions and for a revaluation of the year that has passed. It is not possible to cleanse the slate in order to start afresh. Indeed, much is of such immense value that we cherish it, choked as it may be with obstacles and weighty problems.

What does the physician find recorded indelibly in the record of 1956? The use of radioactive isotopes as "tracer elements" has been a great boon to medical researchers. Poliomyelitis, that dread disease of youth, has shown a striking downward trend both in incidence and mortality rates with the development and utilization of the Salk vaccine. The hypotensive drugs are adding years to the lives of the victims of cardiovascular disease. Cardiac surgery is attaining what seemed to be inconceivable heights a decade ago. Psychiatry is no longer the backward child of medicine but with the aid of tranquilizing drugs is now coming into its own. Occupational medicine, now recognized as a specialty, challenges the physician of the manufacturing plant, the university, and the mercantile organization as never before. Hospital facilities are being extended through the aid of Hill-Burton funds to areas heretofore lacking in proper provision for the sick. Socialized medicine, at least for the present, is not rearing its forbidding head to threaten the intimate physician-patient relationship.

Fortunate as we are who are privileged to practice medicine in this free land, we cannot isolate ourselves from other countries whose problems may

be similar to or vastly different from our own. Great Britain is faced with increasing problems created by its National Health Service. The national economy is in a precarious situation in many countries on the continent of Europe, and poverty, starvation, and oppression appear on every side. The turmoil in the Middle East and the racial struggle in Africa all have their impact upon us, even in our clear atmosphere of freedom.

The spirit of altruism which we may show in giving our all rather than in expecting only to receive, in sharing with the nations of the world the advances of medicine which have been granted to us—all this may go far to encourage the spirits of despairing folk and serve as administering channels through which a Divine Power can supply the leaves from the tree of life for the healing of the nations.

A Man Drives As He Lives

We wish that every one—doctor, lawyer, policeman, and plain people could read "Why Do Accidents Happen?" which we are privileged to publish in this issue of the *JOURNAL* by special permission from *Consumer Reports*. The name of the author is not given, but we suspect he is a physician and he has discussed the causes of automobile accidents in the light of technical understanding of the frailties of the human machine. Several comprehensive studies at the Harvard School of Public Health by Dr. Ross McFarland and his associates and observations of Drs. Tillman and Hobbs in the *American Journal of Psychiatry* are quoted.

In these days with all highways overburdened with increasing millions of automobiles, each operated by a human being, this article is most timely. The drug of fatigue along with the other drugs is one of the great causes of crashes, injuries, and fatalities. With our local interest in the Cornell Automotive Crash Injury Research Project out of which has already come the development of improved automobile construction and many safety devices built into the car to cut down the injuries in the event of accident, our attention should next be turned to safety devices to be built into people.

Medicine's Contribution to World Peace

Medicine is universally recognized as one of the great worldwide arts and sciences that bind humanity together with a language and a purpose transcending all differences of race, creed or color.

To make the language of medicine more articulate in the cause of international peace and human progress, the doctors of the free world are united in The World Medical Association, whose membership now embraces 53 national medical associations.

But it is never enough to establish great institutions. Only when individuals are given an opportunity to play an active part does any human organization "come alive" and begin to realize its basic purposes.

Every American doctor knows first hand the vital role he may play in guiding and protecting his profession by becoming an active member of his county, state and national medical societies.

Today every American doctor has the opportunity—and the imperative challenge—to help make our profession a stronger influence for world peace. This he may do by joining our own United States Committee of The World Medical Association.

Similar "supporting committees" have been organized in a number of other leading nations whose national medical societies, like the AMA, are members of WMA.

In a timely action, WMA, at its 10th General Assembly in Havana in October, adopted a six point program to implement one of its constitutional purposes; to promote world peace. This program includes the development of mutual exchange visits of foreign doctors; exchanges of distinguished medical teachers; establishment by each WMA member national association of an "international visitor's bureau;" stimulation of visits by representa-

tives of member associations to the annual meetings of other member associations; holiday exchange programs between doctors and their families; and exchanges of text books and medical and scientific publications.

To implement this program takes money—and interested members. YOU may play your part by joining the U. S. Committee of WMA. Active membership dues for 1957 are \$10. To join the U. S. Committee—and to learn how you can contribute to this great cause—communicate with S. B. Weld, M.D., 85 Jefferson Street, Hartford 14, Connecticut.

Why Blue Shield Must Keep on Growing

Ever since the birth of the "Blues," the big news has been their astounding rate of growth. Blue Cross and Blue Shield have "hit the jackpot" in public acceptance, the former now well past the 50 million mark, and the latter expected to reach 40 million by the end of 1957.

Occasionally one hears the suggestion that Blue Shield attempt to "stabilize" its enrollment, and relax its efforts to cover an ever larger cross section of the population. But the demand for prepaid medical care is now almost universal; and those who have it are asking for broader coverage and better contracts.

Not only does Blue Shield's momentum of growth permit no turning back, but it has grown so big that the public interest in Blue Shield has made it a major item in America's program for social progress. The continued growth of Blue Shield is essential to the best interests of both medicine and the public.

Why essential?

First, because Blue Shield is a major factor in medicine's economy. Whereas installment buying creates a debt and mortgages the future, medical prepayment creates a credit for the patient, and protects his future.

Again, Blue Shield's growth safeguards its actuarial base of operations. As risks are spread ever more widely, the community and the doctor gain a surer protection against fluctuations affecting the subscription rates or payments to physicians.

A third benefit of Blue Shield growth is the opportunity to reduce operating costs per person enrolled. This helps the plan to broaden its services or to raise its payments to doctors—or both.

Fourthly, the greater the number of his patients covered by prepayment, the fewer for whom the doctor has a collection problem, and the lighter his load of free or part-pay work.

Medicine's most significant benefit from the growth of Blue Shield is the dominant influence of the medically guided Blue Shield Plans on the shape and destiny of the voluntary health insurance movement as a whole. Were it not for Blue Shield, the medical profession would have no effective control over the basic economy of private practice.

Blue Shield is big because it has a big job to do for the doctor and his patient. But the size of Blue Shield is only a reflection of the vision and boldness that the American doctor has brought to bear on this job.

Dr. Allan Ryan and the Journal AMA

Just prior to the holding of the 11th Olympiad in Melbourne, Australia, the *Journal of the American Medical Association* devoted a major portion of one of its issues (November 17, 1956) to articles on the Olympic Games and to various aspects of the field of sports. Three of the articles and a guest editorial in the same issue bear the name of one of our own members as author, Allan J. Ryan of Meriden, a member of the editorial board of this JOURNAL.

It is with considerable pride that more than one Connecticut physician has commented on this accomplishment by Dr. Ryan. His historical account of the Olympics is full of action and serves well to provide the reader with a proper concept of these games throughout the centuries. In his condensation of Ludwig H. Joseph's "A Medical History of Gymnastics" he again shows his ability to select the important and the interesting for the busy reader. The third article, "The Physician as a Sportsman," contains considerable local color as it recounts the outstanding performers in the various sports from among members of our profession. Along with Dr. Ryan's contributions, among several by other authors is one by Mr. Kiphuth, director of the Payne Whitney Gymnasium at Yale.

Allan Ryan is to be congratulated for this outstanding job done in the interest of American medical literature. But these and similar articles carry

with them a far more important message to our busy professional and business men and to the youth of America, viz., that exercise is important for good health and that if we as a nation are to maintain our place as a strong people we must heed the warnings of the investigators who tell us that we are getting soft. Perhaps there is a lesson for us too in the final results of the 11th Olympiad.

The Progress of Dentistry in Connecticut

The History of the Connecticut State Dental Association written by Dr. Jacob Sharp is an inspiring story of ninety two years of progress dating from 1864 when thirty one dentists met in Hartford to become founding fathers. Dr. Sharp has a capable and inquisitive pen and is facile in depicting the dramatic aspects of the lean and fat years of the Association's life.

Connecticut medicine has a proper pride in her so-called firsts. Dentistry in our State has high honors of her own in this category in the contributions of such figures as Horace Wells who gave to the world the benefits of anesthesia, Horace Hayden, president of the first established dental college in the world, Emeline R. Jones, the first woman dentist in the United States, and Alfred C. Fones, a pioneer in the Dental Hygienist Movement. These are but highlights in the honorable history of Connecticut Dentistry.

The story of the Association's efforts in securing good dental legislation is reminiscent of similar struggles of the State Medical Society. Great credit must go to the Dental Association for the passage of the present Dental Practice Act, in 1953. The war record of the Association is one of general pride for by late 1944, two hundred and fifty Connecticut dentists had joined the Services.

This book is enjoyable reading and it belongs in the physician's library. He will find within its pages many professional friends, present and past. More than that he will recognize here the same qualities of devotion which he associates with the great ideals of his own profession. We congratulate the Association on its march of progress and the able historian who has given us a fine account.

THE PRESIDENT'S PAGE

AN indication of what can happen to freedom of medical action, free choice of physician, and free choice of hospital when an autocratic third party takes over control of health matters is exemplified in recent reported happenings between the Pennsylvania State Medical Society and the United Mine Workers Welfare and Retirement Fund.

Our January 16, 1956, the Pennsylvania State Medical Society and the United Mine Workers Welfare and Retirement Fund came to an agreement covering broad principles for medical care of the beneficiaries of the Fund, the details of which can be found in the May 12 issue of the *Journal of the American Medical Association*. This agreement, which was hailed at the time as a model for future negotiations between physicians and union health plans, has been declared by the Pennsylvania State Medical Society "null and void, terminated and ended," after a trial period of only nine months.

At the time of the agreement the Pennsylvania Medical Society was not satisfied with all the details and recognized that the agreement did not solve all the medical problems involved. It did believe, however, that the agreement was a forward step and that it had "prevented some unwise restrictions and regulations which would threaten not only our professional freedom, but deter us from giving that high quality of medical care which the people of Pennsylvania so justly deserve."

The decision of the Pennsylvania State Medical Society to abrogate the agreement was by an unanimous vote of the House of Delegates at its annual meeting. The action was taken after members of the medical staff at one of the general hospitals charged that the union had boycotted this hospital and, except in cases of emergency, had refused to pay bills incurred by its beneficiaries in this hospital, on the grounds that the staff of the hospital had refused to accept United Mine Worker sponsored physicians. The House of Delegates contended that this was "a plot" by the United Mine Workers Fund to "pack" the medical staff and eventually seize control of the hospital.

This is an example of what can happen when union controlled third parties who pay the medical bills interject themselves between physicians and their patients and determine for their workers which hospitals they may enter, which physicians they may have to take care of them and how these physicians shall be paid for their services.

The Pennsylvania State Medical Society has experienced what can happen when freedom of medical action for the public, the physician and the hospital is the decision of a powerful third party controlled by laymen, and its House of Delegates has taken action that could be followed to advantage by other State Medical Societies. They endorsed "fee-for-service" as the only acceptable method of payment and directed a special committee to define fee-for-service payment. They also set up a special committee to draft a set of principles governing physicians' relations with all "third party" groups including government, management, insurance companies and unions.

American Medicine must become actively concerned about these matters because of potential exploitation. It must unite in insisting upon freedom of medical action for itself and the public, otherwise the practicing physician may soon find that he is no longer free, but the servant of third parties.

Ralph T. Ogden, M.D.

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CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

Telephones: UN 5-0587, LO 2-0836

HOUSE OF DELEGATES RESOLUTION ON SOCIAL SECURITY REFERENDUM

The House of Delegates at its semi-annual meeting in Hartford on December 6 passed the following resolution:

In the interests of the physicians of the State of Connecticut, the House of Delegates of the Connecticut State Medical Society instructs the executive secretary to conduct a referendum on the question of compulsory social security for physicians; this referendum to be conducted within 60 days after the publication of an article in favor of social security for physicians and an article against social security for physicians have been published in two consecutive issues of the CONNECTICUT STATE MEDICAL JOURNAL. These articles to be re-printed and mailed to each member of the Society when the referendum is held and all ballots to be returned and tabulated within 30 days of their mailing.

Council Meeting

A regular meeting of the Council was held at the offices of the Society in New Haven on Wednesday, November 14, 1956. The meeting was called to order by the chairman at 3:00 P. M. There were present in addition to the Chairman Dr. Fincke, Drs. Ogden, Walker, Couch, Barker, Weld, Dana-her, Gibson, Feeney, Stringfield, Gallivan, Tracy, Otis, Archambault, Kristan, Meyers, Buckley, Dwyer, Gilman. Absent: Drs. Murdock, Ursone, Gens, Clarke, Starr.

Note: Dr. Joseph J. Kristan, Rockville, was welcomed as the first Councillor from Tolland County to be present at a meeting of the Council for many years.

The Council approved the recommendation of the Committee on Industrial Health that Dr. Denis S. O'Connor, New Haven, be nominated for the 1956 President's Award to the physician who has made an outstanding contribution to the employment of the physically handicapped.

Invitations were presented from the Council on Medical Service of the American Medical Association and Dr. Stanley H. Osborn, Commissioner of Health for the State of Connecticut, for the Society to send a representative to the U. S. Public Health Service Regional Seminar on the "Health of the Aged" that will be held in New York City on December 7, next. It was voted that Dr. Edwin R. Connors, Bridgeport, be invited to represent the Society at this meeting. (Note: Dr. Connors could

not accept this assignment and Dr. James R. Miller, Hartford attended to represent the Society.)

It was voted that Max Alpert, Bridgeport, and John P. Simses, Bridgeport, members of the executive committee on Eye, Ear, Nose, and Throat Section, be appointed members of the Committee on Eye Care to succeed R. M. Fasanella, New Haven, and Sherburne Campbell, Wallingford, who have resigned. It was also voted that Norbert W. Humpage, Torrington, and Merrill Grayson, New London, be nominated to the House of Delegates at its semi-annual meeting on December 6, 1956, to be elected as additional members of the Committee on Eye Care.

The Society's budget for 1957 was presented by the Treasurer, Dr. Couch. It included a recom-

mendation that the per capita dues for 1957 be \$30. The proposals made by the Budget Committee as presented by Dr. Couch were discussed briefly and the budget and dues recommendation for 1957 were approved by the Council without change.

A report of the Building Fund was presented.

Dr. Gibson presented a progress report for the subcommittee to review activities and operations of standing and special committees of the Society. No definite recommendations were contained in this progress report.

A request was presented from the Committee on Industrial Health asking that the Society publish 7,500 copies of a booklet containing the "Code of Ethics Relating to Occupational Medicine" as compiled by the Committee on Industrial Health and published in the May, 1953 issue of the *CONNECTICUT STATE MEDICAL JOURNAL*. These copies of the Code to be distributed among all physicians in Connecticut, unions, employers, and the Connecticut Manufacturers Association. This proposal was discussed at length and a detailed explanation given by Dr. Gallivan. It was finally voted to not approve the request from the Committee on Industrial Health, and Dr. Gallivan agreed to personally explain the reason for this action to Dr. Kilgus, chairman of the Committee.

Dr. Danaher presented a full and comprehensive report of the Conference on MEDICARE in Washington, D. C., on October 29 and 30, which was attended by Dr. Danaher and Dr. Barker as representatives of the Society, and Dr. Horton and Mr. Jordan as representatives of Connecticut Medical Service. Dr. Danaher's report was supplemented briefly by Dr. Barker.

The State Program proposed by the Department of Mental Health and reviewed and reported upon by the Society's Committee on Mental Health was discussed, and it was voted that the Council approve the ten objectives contained in the first part of the program proposed by the Department of Mental Health.

Dr. Danaher presented the tentative draft for a "Credo" for Connecticut medicine and a discussion of "Physicians and Prepaid Medical Plans." These documents had not been received in time to deliver to members of the Council for consideration before the meeting and they were discussed only briefly.

Dr. Danaher requested that they be referred to the newly constituted Subcommittee on the Report

of the Committee on Hospitals, and that copies of them be distributed to members of the Council with the mailing of the minutes of this meeting.

The chairman of the Council opened the discussion of the makeup of the "Augmented Subcommittee to Study the Report of the Committee on Hospitals" in accordance with action taken by the Council at its meeting on October 17, 1956. Dr. Fincke made a number of proposals for this committee including nonmembers of the Council. He also pointed out that the purposes and objectives of the committee had changed since it was first appointed and its responsibilities broadened. After full discussion it was agreed that the chairman of the Council add to the present committee, which now consists of four members, three others—all to be members of the Council, making a total of seven, and to designate the chairman of the Committee—Dr. Ogden wishing to withdraw as chairman. Following the meeting, the chairman directed the executive secretary to invite the following to serve on this committee: to be chairman, Dr. Weld; Drs. Ogden, Gallivan, Fincke, Gilman, Archambault, Murdock. Dr. Barker is not to continue as a member of the committee, but is to be designated as its recorder and attend meetings *ex officio*.

Dr. Stringfield, chairman, presented a very informative report of the State Poliomyelitis Vaccine Advisory Committee, and it was agreed that Dr. Stringfield present a report to the House of Delegates at its semi-annual meeting on December 6.

Thirty two student members were elected, and it was noted that among them was James Irving Gilman, Yale Medical School 1960, son of Ralph L. Gilman, Alternate Councilor from Windham County.

The executive secretary presented a letter from Dr. N. M. Hotchkiss, Norwalk, representing the Connecticut Osteopathic Association. In this letter Dr. Hotchkiss asked the State Medical Society to designate representatives to meet in conference with representatives of the State Osteopathic Association for the purpose of discussing problems of mutual interest with particular primary reference to the presentation to the 1957 Connecticut General Assembly a bill that would create a Composite Examining Board for the examination and uniform licensure of Doctors of Medicine and Doctors of Osteopathy. In discussion, the executive secretary referred to previous experiences of this kind and attempts on the part of osteopaths to extend their

field of licensure and practice. It was agreed that the chairman of the Council appoint such committee and that it include a representative of the Connecticut Medical Examining Board and the executive secretary. Following the meeting the chairman of the Council informed the secretary of these appointments to this Committee: Chairman, Louis P. Hastings, Hartford; Alfred L. Burgdorf, Hartford; Willard E. Buckley, Middletown; Creighton Barker.

Recommendations were presented from the Committee on Eye Care relating to Vision Testing of School Children. These were discussed briefly, and it was voted to present these recommendations to the House of Delegates at its semi-annual meeting on December 6 with the approval of the Council.

Dr. Feeney, chairman, presented and discussed a statement of Principles of Cooperation that had been drafted and approved by the Joint Conference Committee of the State Medical Society and the State Bar Association. These principles were approved by the Council with the correction of a minor error in paragraph VII, and it was voted to present them to the House of Delegates for approval at the semi-annual meeting on December 6.

It was voted that the next meeting of the Council be held at the offices of the Society on Thursday, December 20. The meeting adjourned at 6:45 P. M.

Meetings Held in December

- December 3—Board of Directors Woman's Auxiliary
- December 5—Clinical Congress
- December 6—Clinical Congress
 - Dinner for Dr. Dwight H. Murray, president American Medical Association
- December 12—Advisory Committee to State Blood Bank
 - Accident Prevention Committee
- December 18—Program Committee, 1957 annual meeting
 - Board of Directors Connecticut Medical Service
- December 20—Council
 - Committee on Public Relations

Nominating Committee

The 1957 Nominating Committee will begin its meetings soon to consider nominations for officers

and committee members for 1957-58. Proposals and suggestions should be sent to secretary's office promptly.

AMA Studies Uniform Chemical Labeling Law

A program to protect the public from the dangers of mislabeled household and commercial chemicals recently was launched by the American Medical Association. Through its Committee on Toxicology, the AMA is gathering information on existing State labeling regulations with the idea of developing model legislation on the precautionary labeling of various chemical products—such as paints and paint removers, heating and cooking fuels, household polishers and cleansers, laundering items, etc.—which are not now so regulated. The end result would serve as a guide for writing uniform regulations requiring labels to show information on the product's contents, its possible dangers, directions for safe use, and first aid instructions.

Bernard E. Conley, PH.D., Committee secretary, reports that there are at least a quarter of a million different trade-name substances now on the market. Without proper labeling, both physicians and the public may be uninformed about harmful materials these products contain and the ways of treating poisonings from them.

Other organizations, including the American Academy of Pediatrics, American Public Health Association, American Pharmaceutical Association, National Safety Council, leading trade associations and various State and national governmental regulatory agencies are being consulted on this problem and its solution.

New Home for Oklahoma Medical Association

The Oklahoma State Medical Association has joined other similar medical groups in constructing its own headquarters building. The new building is functional in design, with half of it designed for office space and the remainder constructed to serve as meeting rooms. Construction of the building was proposed in 1954 by the Association's House of Delegates, and approved in 1955. Construction work got under way in May, 1956, and the employees moved in September 1, 1956.

PROGRESS IN CLINICAL MEDICINE

NEW DRUGS IN THE TREATMENT OF EMOTIONAL DISORDERS: A REVIEW

PAUL N. GRAFFAGNINO, M.D. and JOHN H. FURR, M.D., *Hartford*

FOR the past several years the pharmacological aspects of psychiatry have attracted a growing interest and hopeful enthusiasm. Many drugs have received attention both experimentally and therapeutically. As a result of such a study of rejuvenation of psychiatric research and treatment has occurred. Recently there has been valid criticism expressed by many clinicians concerning the sometimes indiscriminate use of the new drugs. The need for caution in the evaluation of their properties becomes greater. The following article is a review of the data presently available on some of the new preparations as well as an evaluation of the experiences with these agents on patients in a private psychiatric hospital over the recent years. It must be remembered that the current interest in drugs represents only one aspect of the problem of emotional illness. Treatment of the whole person is essential. The search for causes must continue before definitive cures for emotional problems can be developed.

The purpose of the present article is, first, briefly to acquaint physicians with some of the new areas of psychiatric research and, secondly, to discuss the clinical use of the new drugs used in psychiatry. The nonpsychiatric use of the various drugs to be discussed is not within the scope of this article and, therefore, will not be mentioned.

PSYCHOMIMETIC DRUGS

One area of research involves the so-called hallucinogenic, or psychomimetic drugs. These drugs evoke experiences which many workers believe to be identical with or similar to the experiences of psychotic patients. One such drug is mescaline. This drug is obtained from a cactus plant from the American Southwest. It has been used by American Indians in religious ceremonies for centuries. In the 19th century mescaline attracted wide attention from many scientific workers, including Wier Mit-

From the Institute of Living, Hartford, Connecticut

Dr. Graffagnino. *Resident in Psychiatry, Institute of Living, Hartford, Connecticut*

Dr. Furr. *Resident, Institute of Living, Hartford, Connecticut*

SUMMARY

In this presentation the authors survey the latest "miracle" drugs used in the treatment of emotional disorders. They make no claim to anything in the way of original clinical contributions but do make several keen but minor observations almost as asides.

In the area of research the so-called hallucinogenic or psychomimetic drugs are discussed including mescaline and d-lysergic acid. Reversing the symptoms of these two drugs are Frenquel and Meratran. Another drug, Ritalin, receives a few lines in passing.

The tranquilizing or ataractic are considered the most important therapeutic drugs in psychiatry. These include chlorpromazine, reserpine, promazine and meprobramate.

Although this review deals with drugs, the authors remind their readers that these pharmacological aids do not constitute the basic cure of emotional problems.

chell, Havelock Ellis, and William James. Interest in this compound reawakened in 1943 when a synthetic compound, d-lysergic acid (LSD), was found to produce reactions similar to those of mescaline in humans. Both mescaline and LSD produce in normal subjects a psychotic reaction characterized by hallucinations, disorders of perception, depersonalization, feelings of unreality, and emotional disturbances. These two drugs have attracted attention because the experimental psychoses so produced occur without confusion or disorientation. Subjects are therefore able to report their experiences during the psychosis. Many workers believe that these psychotic reactions closely resemble schizophrenic

reactions. If this is true, mescaline and LSD might be valuable in investigating the etiology, physiology, and symptomatology of the schizophrenias. Whether or not these drugs cause true schizophrenic reactions is not established, but in any event it seems certain that the interest which their study has evoked will enhance our knowledge of brain physiology and of behavior.

Other drugs have subsequently been found to inhibit or counteract the psychoses produced by mescaline or LSD in normal subjects. Consequently, research workers have begun to investigate the effects of these drugs on the symptoms of schizophrenic patients. Among the compounds which have been reported to block or reverse the symptoms of mescaline and LSD psychoses are Frenquel* and Meratran.† Chlorpromazine and reserpine have been reported to have a similar action but these compounds were used clinically before their effect on experimental psychoses was investigated.

FRENQUEL

Experimental studies have revealed that Frenquel inhibits or reverses the hallucinations induced by mescaline or LSD in normal subjects. This led to clinical investigation of the effect of Frenquel on psychotic patients in whom hallucinations were prominent symptoms. Reports of the clinical use of this drug in psychiatric patients have varied in their appraisal of its therapeutic value. Almost all reports agree that Frenquel's antihallucinatory effects are inconsistent and unpredictable. Its value as a tranquilizing agent is even less well substantiated. The therapeutic value of Frenquel is still being studied. Further investigation is needed before its use in office practice can be recommended.

MERATRAN

Meratran is chemically similar to Frenquel but has greatly different clinical properties. It is a central nervous system stimulant, but, unlike the amphetamines, it appears to have no sympathomimetic action. It seldom causes anorexia, hypertension, anxiety or insomnia. Its most important clinical use is that of counteracting the lethargy and depression which often occur in patients receiving tranquilizing drugs, antihistamines and anticonvulsants. It has a limited value in the treatment of certain mild reactive depressions, but it should be emphasized

that patients who are moderately or severely depressed should not be expected to respond adequately to Meratran. No known drug is effective in such depressions. These reactions are usually protracted and progressive. Moreover, the risk of suicide must always be considered. Electroconvulsive therapy remains the treatment of choice for severe depressive reactions. Meratran has also been used in disturbed children and agitated elderly patients for its quieting action. Whether or not it will prove as successful as the amphetamines in such patients is unknown at present.

The dosage of Meratran ranges from 3 to 25 mgs. daily by mouth. It is usually advised that the beginning dose be 1 mg. three times a day. If there is no therapeutic effect in one week, the dosage may be increased to 2.5 mgs. three times a day. This method of increasing the dosage may be continued until a therapeutic effect occurs or until undesirable side reactions such as anxiety, agitation, restlessness, insomnia or anorexia appear.

Meratran is contraindicated in patients who are anxious, agitated, overactive, excited or restless. There is evidence that it will intensify or provoke symptoms in obsessive-compulsive patients, schizophrenic patients, and patients with anxiety neuroses. It may provoke psychotic symptoms in prepsychotic individuals.

RITALIN

Another new synthetic central nervous system stimulant is Ritalin. Like Meratran it rarely affects the sympathetic nervous system, the cardiovascular system, appetite or sleep. The indications, side effects and contraindications are similar to those of Meratran. It has been used extensively to combat the lethargy and depression encountered with the use of chlorpromazine and reserpine. It is also used to counteract the hypotensive effects of these tranquilizing agents. The average dosage is 10 mgs. two or three times a day.

TRANQUILIZING DRUGS

The most important therapeutic drugs which have become available to psychiatry recently are the so-called tranquilizing or ataractic agents. The most notable of these are chlorpromazine and reserpine. These drugs are of interest to general medical practitioners for several reasons. The family physician can treat many patients with minor emotional disorders by means of these drugs. With increasing frequency the family physician will be called upon

*The trade name of The Wm. S. Merrill Co. for azacyclonol.

†The trade name of The Wm. S. Merrill Co. for pipradol.

to manage and regulate such medications prescribed for maintenance of patients who have been discharged from psychiatric hospitals and psychiatric services of general hospitals.

Any new drug passes through three phases of clinical evaluation following its introduction and use. The first phase may be called that of over-optimism. This phase usually accompanies enthusiastic early reports. The second is that of over-pessimism, during which the limitations of the agent become apparent and are frequently over-emphasized. The third phase is that of realistic appraisal. Any discussion of drugs must necessarily be influenced by the phase of appraisal through which the particular drug is passing at the present time.

CHLORPROMAZINE

In 1952 French research workers in the Rhine-Poulenc Laboratories became interested in the sedative action produced as a side effect by certain antihistamines. In an attempt to identify the sedative properties of Phenergan they derived a compound which had the sedative but not the antihistaminic action of Phenergan. They labelled this compound 4560 R.P. It was under this name that French clinicians began testing the drug in psychiatric patients. This agent was later called Largactil in Europe and Canada and chlorpromazine* in the United States. It was found to have a remarkable quieting effect on certain psychiatric patients, notably severely agitated manic individuals. The drug is notable in the history of psychiatry because it was the first sedative which produced a calming effect in severely agitated patients without clouding of consciousness.

Extensive clinical experience since that time has shown chlorpromazine to be of considerable value in the treatment of the more severe psychiatric disorders.¹⁰ It is less effective in the office and out-patient management of minor emotional disorders. Chlorpromazine is indicated for the relief of acute and chronic anxiety, tension, hyperactivity, and agitation. Such symptoms may be associated with a variety of psychiatric conditions including schizophrenic reactions, manic states, severe anxiety and panic reactions, alcoholic and narcotic withdrawal syndromes, and organic brain syndromes. Chlorpromazine is equally effective in patients of all age groups.

* The trade name of Smith, Kline & French for chlorpromazine is Thorazine.

The drug has its most pronounced effect in the correction of disturbances of emotion and behavior. It has considerably less effect on disordered thinking. Thus, patients often remain delusional or irrational as their behavior and emotional state improve.

The therapeutic dosage varies greatly according to the patient and must be determined according to the reaction of the individual. Many patients treated in office practice are relieved of their symptoms with as little as 10 to 25 mgms. three times a day. Others require up to 100 mgms. three times a day. Bonello,⁴ as a result of his extensive experience with this drug in general practice, advises that whenever a patient requires more than 300 mgms. of chlorpromazine daily, a psychiatrist should be consulted.

The onset of therapeutic effect of chlorpromazine generally occurs within twelve hours. Its action persists for two or three days following discontinuation of the drug. In most instances the preferred mode of administration is by mouth. Intramuscular administration occasionally is indicated in acutely disturbed patients. Such injections are painful and oral administration should be initiated as soon as possible.

At times the drug is limited in its use because of certain toxic reactions and side effects. The most serious toxic reaction is agranulocytosis. This complication is rare and is not dependent on the size of the dose. Weekly or biweekly white blood counts are definitely indicated in all chlorpromazine treated patients. Another toxic reaction is jaundice which has been variously reported to occur in 1.4 per cent to 4.8 per cent of all chlorpromazine-treated patients.⁶ Liver biopsies in patients with such jaundice reveal a mild and reversible damage to the centrilobular hepatic cells. There is an accompanying bile stasis in the biliary canaliculi near the center of the lobules. The clinical and laboratory picture is that of obstructive jaundice. There is little or no evidence of hepatic cell damage as manifested by liver function tests. The incidence of jaundice bears no relationship to dosage or duration of therapy. It is wise to follow chlorpromazine patients with routine icterus index or serum bilirubin determinations at biweekly to monthly intervals. At our hospital we have found the icterus-index determinations to be of greater value in detecting preclinical jaundice than serum bilirubin determinations.⁹

Most contraindications to the use of chlorpromazine are relative and are not yet accurately defined. It should be used judiciously and cautiously in

patients with hepatic disease, advanced cardiovascular disease and peptic ulcer. An absolute contraindication is leukopenia. Since chlorpromazine potentiates the action of alcohol, barbiturates and other central nervous system depressants, it should be used with caution in patients receiving such drugs. Because of its hypotensive effects, chlorpromazine should be employed cautiously in patients with coronary artery disease or cerebral arteriosclerosis. It may cause an exacerbation of peptic ulcer symptoms. Bleeding has been known to occur when chlorpromazine has been administered to patients with a history of peptic ulcer. The physician should be alert to the fact that the tranquilizing effect of chlorpromazine may mask the symptoms of bronchopneumonia and acute intra-abdominal disease in elderly patients. Chlorpromazine is not indicated in persons whose predominant symptoms are those of depression. Such symptoms are often intensified and sometimes brought on by the medication.

Certain side effects occur with relative frequency but these are transient or readily reversible. In some instances reduction of the dosage is sufficient to relieve such symptoms. These symptoms include urticaria, hypotension, dryness of the mouth, tachycardia, febrile reactions, nasal congestion and constipation. Parkinsonism, urinary incontinence and occasional convulsions have been reported. Photosensitivity of the skin is another side effect. The side effects may usually be treated without discontinuation of the drug. All patients receiving chlorpromazine should be advised to avoid prolonged exposure to sunlight. Antihistamines are helpful in relieving both nasal congestion and skin reactions. The occurrence of parkinsonism usually calls for a decrease in the dosage of chlorpromazine. However, it rarely necessitates discontinuing the medication and anti-parkinsonian agents may be administered concurrently. We have found Phenergan to be especially valuable in controlling allergic reactions and parkinsonism.

RAUWOLFIA

Unlike chlorpromazine, which has been in existence for only a few years, the Rauwolfia or snake root plant has been used in India for over five centuries. It was used for treatment of insanity, epilepsy and insomnia. Modern medical interest in the properties of the powdered root of this plant began with published reports in medical journals of India in 1931. It is interesting that in these reports

therapeutic emphasis was on the psychiatric properties of the drug. It was not until 1952 that the active sedative alkaloid, reserpine, was isolated. In America clinicians had begun as early as 1950 to study the crude preparation in the treatment of hypertension. The psychiatric properties of the drug were among the last to be studied in Western countries.^{2,5,10} By 1953 these properties were being studied. Widespread use of the drug in psychiatry began late in 1954.

Indications for the use of reserpine are similar to those of chlorpromazine, described herein.

The onset of improvement in patients receiving reserpine occurs later than with chlorpromazine. Reserpine often manifests no effect before 24 to 48 hours, although large parenteral doses will usually show some effect within a few hours. Reserpine resembles other therapeutic alkaloids such as digitalis, not only in its slow onset of action but in the persistence of its action after it has been discontinued. Effects of reserpine continue for a period of about three to seven days following cessation of treatment. When smaller doses of reserpine are used, improvement may not be seen for weeks or months. Smith⁸ recommends that final judgment of the therapeutic effect of reserpine be evaluated in no less than three months after the institution of therapy.

According to Kline, there is frequently a definite sequence in the reactions of patients to reserpine. These have been called the sedative, the turbulent, and the integrative phases of reserpine therapy. Unless the physician is aware that the turbulent phase occurs and that it is transitory, he may be tempted to discontinue the drug prematurely.

As with the other tranquilizing drugs the dosage will vary greatly according to the individual. In office practice a dosage range of 0.25 to 2 mgs. daily has been recommended. Some patients require as much as 5 mgs. a day. An advantage of reserpine over the other tranquilizing drugs is that it can be administered only once daily because of its prolonged effect.

Reserpine causes more uncomfortable side reactions but fewer serious toxic effects than does chlorpromazine. Agranulocytosis has been reported much less frequently than with chlorpromazine. No cases of jaundice are known to have occurred. Side effects include: lethargy, edema, hypothermia, bradycardia, hypotension, nasal congestion, nausea, vomiting, diarrhea and parkinsonism. Generally

most of these side effects can be treated with appropriate symptomatic measures without discontinuing the reserpine. At times such symptoms may be relieved by decreasing the dosage. Ritalin, which is discussed above, is of value in counteracting the lethargic and hypotensive effects of reserpine. Management of other side effects is similar to that for the side effects of chlorpromazine.

The chief contraindication to the use of reserpine is the existence of depressive symptoms. To an even greater extent than chlorpromazine, reserpine is likely to intensify symptoms of depression. Moreover it often evokes depressive symptoms in individuals who previously had manifested no such symptoms. The depressive reactions intensified or precipitated by reserpine have sometimes been sufficiently severe to require electroconvulsive therapy.

PROMAZINE

Promazine* is a tranquilizing agent of more recent origin. It is one of a number of compounds which were synthesized and studied because of their close chemical similarity to chlorpromazine. This drug appears to be similar clinically to chlorpromazine in many respects. However, few studies of this new medication have been reported at present. Like chlorpromazine it appears to potentiate the action of barbiturates and alcohol. Preliminary reports indicate that promazine is effective in the control of anxiety and agitation.

These reports also indicate that promazine has fewer undesirable side effects than does chlorpromazine. Despite these reports, it would seem wise in most instances to use the more established and better known tranquilizing agents until the properties of promazine are more fully known and confirmed.

MEPROBAMATE

Meprobamate†^{3,7} is a newly developed tranquilizing agent which differs in certain important respects from chlorpromazine and reserpine. This compound was synthesized in 1950. It was studied because of its chemical similarity to mephensin,‡ a skeletal muscle relaxant. A more potent and longer acting drug than mephensin was sought. Meprobamate satisfied both of these requirements. By 1954 it had been discovered that this drug also had the

property of relieving anxiety and apprehension. Meprobamate exerts a calming and relaxing effect in patients who are hyperactive and agitated. It is an effective drug in the treatment of tension headaches. Some reports claim that it relieves mild depressions by its capacity to alleviate tension and anxiety without intensifying the depression. It has an effective hypnotic action without some of the undesirable aspects of barbiturate hypnosis. Meprobamate has been reported to be of therapeutic value in the treatment of neurodermatitis. Psychoneurotic patients appear to respond more satisfactorily to this drug than do psychotic patients. In psychotic disorders, chlorpromazine and reserpine remain the tranquilizing agents of choice.

When used as a tranquilizing agent the dosage of meprobamate ranges from 400 to 800 mgs. four times a day. As a hypnotic agent its dose is 800 mgs. at bedtime. The only available mode of administration at present is the oral one.

The toxic and side effects of meprobamate which have been reported are angioneurotic edema, urticaria, syncope, fever, drowsiness and headaches. A considerable number of patients complain of gastric discomfort. However, meprobamate frequently relieves gastric distress caused by emotional factors. Drowsiness caused by meprobamate often disappears within one to two weeks following institution of therapy. If not, it may be relieved by decreasing the dosage. Unlike chlorpromazine and reserpine, meprobamate rarely disturbs the autonomic nervous system.

All the tranquilizing drugs are usually administered for relatively long periods of time. To date there is no conclusive evidence that any of these drugs have addicting properties. In some patients maintenance therapy should be continued indefinitely. In others, a gradual reduction of dosage may permit discontinuation of the drug without return of symptoms. These drugs should not be considered as curative agents. They do not alter the fundamental psychopathology in spite of the fact that symptoms may be significantly relieved. In most of these patients psychotherapy is necessary, whether this be periodic reassurance and support by the family physician or intensive dynamic therapy by a psychiatrist.

This article has presented only a few of the number of chemical compounds which are currently receiving attention and study in psychiatry and its

*Sparine is the trade name of Wyeth for promazine.

†Trade names are Equanil (Wyeth) and Miltown (Wallace).

‡Trade name is Tolserol (Squibb).

related fields. The drugs presented are those which have been more thoroughly studied, those which have had more clinical and therapeutic application, or those which appear to offer greater therapeutic promise. It is to be expected that research within the years to come will increase our knowledge of both pathological and normal mental processes. Furthermore, it seems likely that an increasing number of drugs will become available for the treatment of psychiatric patients.

The use of psychiatric drugs has already increased the number of patients discharged from mental hospitals and this trend may be expected to continue. This means that the family physician will be called upon with an ever increasing frequency to manage and treat psychiatric patients. Fortunately, he will have at his disposal a group of new drugs and a body of new knowledge resulting from continued laboratory and clinical research within the field of psychiatry. The basic cure of emotional problems, however, does not depend upon pharmacological aids alone but rather upon a continuing search for causes and upon treatment of the patient as a whole individual.

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Walls of the AMEF House

A Statement Concerning the American Medical Education Foundation

Would you like to live in a community where there were not competent medical services available to all classes of people; where, when a doctor were needed in an emergency, he could not be secured; where the newest techniques and medications were not used for the security of the community's health? Of course, you would not. No American would.

For the purpose of safeguarding the future health of America the AMEF was organized just a few short years ago.

The main objective of the foundation is to raise funds to assist the 82 medical schools in this country. There are only 82 of them for the 164 million of us. From them come your family doctor, the medical men in our armed service and industry, and all the doctors and surgeons who staff our hospitals and those who participate in the increasingly important field of research.

Medical schools are an indispensable national resource. However, with the increasing operating expenses of these institutions, financial aid must be provided. This is a serious problem.

Few of us realize that the four-year training of a medical student costs the school \$12,000 to \$14,000. Costly equipment is necessary; faculty posts must be filled; and research must be carried on. Medical schools cannot continue to operate on their existing deficits.

The money from the foundation is used:

1. To assure a continual flow of able doctors to our communities, hospitals, and health programs.
2. To assist medical schools in maintaining adequate faculties and material equipment.
3. To continue progress in medical research.
4. To help establish equal educational opportunities for medical students.
5. To safeguard our medical standards and, in turn, our national health.

The medical schools are the heart of the nation's health. They must receive the financial help they need. No foundation, no public funds, no source other than the AMEF is in a position to meet the need so adequately.

Mrs. E. Roland Hill, President
Woman's Auxiliary to the Connecticut
State Medical Society

THE HISTORIAN'S NOTE BOOK

CESAREAN SECTION

ARTHUR E. BRACKETT, M.D., *Riverside*

THE following case of cesarean section is taken from William P. Dewee's "A Compendious System of Midwifery" published in Philadelphia, 1828.

"On the continent of Europe this operation is resorted to at an early period of labour, before the woman is either exhausted by the continuance of unavailing pains, or is in a state almost of gangrene, from fever.

"In France and other parts of the continent, agreeably to Baudelocque one hundred and thirty nine women recovered out of two hundred and thirty cases." (Page 572.)

"An interesting case is related in *Rusts Magazine* which we shall transcribe. 'Caroline Bechang was admitted into Graaf's Clinicum. She was thirty years old, much deformed by rickets and measuring four "Rhenish feet" in height. On the 20th of September, after five days in labour—the pains severe—and the os uteri dilated, she consented to the Caesarian operation. A little after two o'clock Graaf passed the forefinger of his left hand immediately below the umbilicus, and with a large scapel made an incision an inch above of the os pubis, dividing the entire abdomen and even penetrating the substance of the uterus. A second incision was made

to penetrate the uterus, and expose the placenta, which, as had been anticipated, was found on the fore part of the fundus of this organ. The assistants now firmly compressed the edges of the abdominal wall upon the uterus itself, to prevent the protrusion of the intestines, in this they succeeded; and Graaf carried his hand in a moment to the fundus: separated the placenta with his fingers and thumb and then withdrew it and the child almost together. The child was very active and cried lustily. The uterus immediately and suddenly contracted and the bleeding was inconsiderable, for not more than twelve ounces of blood were lost. No ligature was required. The whole operation was completed in four minutes and a half. The wound was secured by three broad sutures and adhesive plasters. The child weighed six pounds and was well formed. The patient passed a quiet night. The symptoms of pain, inflammation and fever were threatening for some days but were promptly retarded by the lancet. The lochia were discharged regularly and in three weeks she was able to sit up. Early in November she returned home with her child both in perfect health'." (Page 573.)

When we remember that they knew nothing about anesthesia or asepsis, we are reminded of Cheselden who removed stones from the bladder in one minute.

Special Article

MEDICARE

Dependents' Medical Care Act of 1956 (PL569)

CREIGHTON BARKER, M.D., *New Haven*

THE Dependents' Medical Care Act, MEDICARE, went into effect one minute after midnight on December 7, 1956. Connecticut was among the first States to function under it when a baby was born to the wife of an Air Force sergeant in New Haven in the early hours of the morning of the 7th. From this fast start it is likely that a program of limited medical care paid for by the Federal Government will be here to stay.

The Act passed by the 84th Congress provided that the Secretary of Defense and the Secretary of Health, Education and Welfare should jointly prescribe regulations for the administration of the law. These regulations set forth that the Departments of Defense and Health, Education and Welfare should enter into contracts with the State Medical Societies in the several states and territories to (a) establish fair charges for professional services provided by the law within the state, (b) designate a contracting fiscal agent to handle claims and make payments, and (c) encourage the physicians within the state to participate in the plan and provide them with pertinent information. By this method of administration the Federal Government has removed itself as far as possible from the administration of this law and voluntarily placed responsibility for its operation and success in the hands of the medical profession locally. It is a challenge that the profession cannot overlook and as time goes on, if this method of administration is successful, it may well set a pattern for additional Federal medical care programs already contemplated.

Services provided under the Medical Care Act are officially stated as follows:

I. Under the provisions of the Dependents' Medical Care Act, dependent spouses and children of members of the Uniformed Services (Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and Coast and Geodetic Survey) on active duty or active duty for training under orders not specifying a period of thirty days or less are eligible to receive

The Author. *Executive Secretary, Connecticut State Medical Society; Coordinator of MEDICARE for Connecticut*

certain medical care from civilian sources at Government expense.

II. Detailed information concerning the kinds of medical care and the circumstances under which this medical care is authorized to be obtained and paid for at Government expense is available at activities of the Uniformed Services.

III. Medical services authorized to be provided eligible spouses and children may include:

a. Hospitalization in semi-private accommodations up to 365 days for each admission, including all necessary services and supplies furnished by the hospital during hospitalization.

b. Medical and surgical care during a period of hospitalization.

c. Complete obstetrical and maternity care. Normally the government restricts payment to one physician within any one trimester of maternity care or for postpartum care. Exceptions may be granted in cases wherein a change of physician was necessary due to circumstances beyond the control of the patient: i.e. permanent change of sponsor's duty station; change of patient's residence involving a considerable distance; death or disability of physician. Patient will pay \$15 to physician in event of home delivery. Such payment will not be made to physician if patient is hospitalized for postpartum care, or if patient has been hospitalized for that pregnancy or a direct complication thereof with a resultant \$25 payment to the hospital.

d. Services required of a physician prior to and following hospitalization for a bodily injury or surgical operation. Patient will normally pay charges for diagnostic tests or procedures in excess of \$75 prior to hospitalization and in excess of \$50 following hospitalization. (Patient will pay for all such tests prior to hospitalization for other conditions.)

e. Diagnostic tests and procedures including laboratory, pathology, and x-ray examinations during hospitalization when ordered by the attending physician.

f. Treatment of fractures, dislocations, lacerations and other wounds when patient is not hospitalized. Patient will normally pay the first \$15 of such physician fee plus cost of diagnostic tests or procedures in excess of \$75.

g. Treatment in a hospital of acute emergencies of any nature which are a threat to the life, health, or well-being of the patient including acute emotional disorders pending arrangement for care elsewhere.

h. Dental care which is a necessary adjunct to medical or surgical treatment rendered in a hospital to a dependent who is a hospital inpatient and concurred in by the attending physician.

IV. Medical service not authorized from civilian sources include:

a. Chronic diseases, except for acute exacerbations or acute complications.

b. Nervous and mental disorders, i.e., neuroses, psychoneuroses, psychopathias or psychoses (except in III g above).

c. Elective medical and surgical treatment desired by the patient which in the opinion of cognizant medical authority is not medically indicated, e.g., surgery solely for cosmetic purposes.

d. Domiciliary type care, e.g., personal care contradistinct to active and definitive treatment.

e. Outpatient care except for the payment of one visit to a physician initially responsible who transfers full care to another physician upon patient's hospitalization and as indicated in III c, d, and f above.

f. Ambulance service.

g. Drugs, medicinals or other medical supplies except those furnished as an inpatient or those administered directly by a physician while providing authorized care.

V. Payment for civilian medical care by patient or sponsor: The patient, or sponsor, will pay directly to the civilian medical facility such portion of the medical expenses as prescribed jointly by the Secretary of Defense and the Secretary of Health, Education and Welfare. This includes generally that the patient or sponsor will pay directly to the civilian medical facility the sum of \$25 or an amount

determined by multiplying the number of days hospitalized by \$1.75, whichever sum is greater.

The Connecticut Fee Schedule, based in so far as was possible upon the schedule of fees allowed under the subscribers Preferred Contract of Connecticut Medical Service, has been compiled by representatives of the Society in conference with a task force of the Department of Defense with the advice of a Special Committee on MEDICARE appointed by the Council. Dr. Thomas J. Danaher, member of the Council, delegate to the American Medical Association and president of Connecticut Medical Service, is the chairman of this committee. Its members are:

Hugh K. Miller, 1959 Summer Street, Stamford, obstetrics-gynecology.

John E. Cartland, Jr., 85 Jefferson Street, Hartford, pediatrician.

Harold M. Clarke, 73 Cedar Street, New Britain, surgeon.

Willard E. Buckley, 105 South Main Street, Middletown, radiologist.

Richard B. Elgosin, 2440 Whitney Avenue, Hamden, general medicine.

Hugh L. Dwyer, 309 Edwards Street, New Haven, internal medicine.

Henry A. Archambault, 2 North Second Avenue, Taftville, surgeon.

R. Bruce Thayer, Jr., Main Street, Hazardville, general practice.

Morton Arnold, 29 North Street, Willimantic, EENT.

Creighton Barker, executive secretary of the Society is the coordinator of the plan in Connecticut.

The schedule of fees includes more than 2,000 items and will be subject to renegotiation if indicated during the present contract period which ends June 30, 1957. Prior to that date an extended contract will be renegotiated with the Department of Defense by the Society.

The fee schedule and details concerning its use will be published by the Society at the earliest possible date and made available to physicians throughout the State. It is contemplated that it may be a supplement to the February issue of the CONNECTICUT STATE MEDICAL JOURNAL. Until it is generally available inquiries concerning fees may be directed to the Society's office in New Haven or to MEDICARE, P. O. Box 755, New Haven 3, Connecticut.

(Continued on page 66)

AMA — SEATTLE — NOVEMBER 27-30, 1956

REGISTERED FROM CONNECTICUT

Thomas P. Murdock, Meriden, Member, Board of Trustees

Thomas J. Danaher, Torrington, Member, Council on Insurance and Medical Service; Member, Reference Committee on Medical Education and Hospitals of House of Delegates

Stanley B. Weld, Hartford, Member, Reference Committee on Credentials of House of Delegates

John N. Gallivan, East Hartford, Member, Council on Industrial Health; Member, Reference Committee on Hygiene, Public Health, and Industrial Health of House of Delegates

Norman H. Gardner, East Hampton, Member, Council on Rural Health; Alternate Delegate

Oliver L. Stringfield, Stamford, Alternate Delegate

Benjamin V. White, Hartford, Alternate Delegate

Captain R. E. Jankowich, Stratford

Scientific Session

The Scientific Session was held at the Civic Auditorium, a large convention hall much like that in Atlantic City, except on a somewhat smaller scale. There were a number of very informative panel discussions, all conducted, at least in part, by nationally known authorities. The subjects included hemolytic anemias, postpartum problems, hypertension, prenatal care, aging, epilepsy, low back syndromes, diseases of the liver, stomach and duodenum, congestive heart failure, diabetes mellitus, and the tranquilizing drugs. These panels afforded an excellent opportunity to catch up on recent developments in the various fields in a critical atmosphere which largely avoided or exposed overenthusiasm for diagnostic or therapeutic measures of doubtful value. The discussions on diabetes and congestive failure were exceptionally informative.

Among the lectures given by individual speakers was one by Howard Spiro and Manuel Friedlander of New Haven on the clinical approach to steatorrhea. Dr. Friedlander pointed out the value of a simple modification of the Sudan III technique for office use in detecting excessive amounts of fecal fat. A saline suspension of feces on a microscope slide is brought to a boil after adding a drop or two of three per cent acetic acid to hydrolyze the soaps, and is then stained in the usual way with a drop of Sudan III. Two or three fat globules per high power field are normal. Beyond that, excess fat is considered to be present. Drs. Spiro and Friedlander consider a flat glucose tolerance curve to be of great value in pointing to mal-absorption syndromes.

They emphasized the frequency of steatorrhea without diarrhea and they advised fecal fat studies on patients with diarrhea supposedly associated with the irritable colon syndrome. They viewed as promising quantitative estimations based on the excretion of oleates iodized with I_{131} .

There were eighty-seven scientific exhibits. As usual, many of these were of statistical and promotional nature. Others were difficult to evaluate and were colored by the enthusiasm of the exhibitors. Still others were clear and informative. Farquhar of Lankenau Hospital in Philadelphia described a study of 500 bacterial infections in children treated with Sulfaethylthiodiazole. This substance gave high blood levels, few side effects and yielded excellent therapeutic results. Most of the children had infections with streptococci and pneumococci. Sjoerdsma of Bethesda gave an excellent demonstration of the cutaneous flushing and right sided cardiac valve lesions seen in malignant carcinoid tumors with metastasis. The changes are supposedly caused by excessive production of serotonin by the argentaffin cells. Serotonin, or trihydroxytyramine, is excreted in the urine as trihydroxyindole acetic acid which can be measured as a simple diagnostic test. Elias, of Chicago, had a beautiful series of photomicrograms and stereographic drawings demonstrating the three-dimensional architecture of the renal glomerulus. Among other things, he demonstrated frequent anastomoses between the loops, which have generally been regarded as distinct from one another. Volwiler of Seattle presented a series of cases of agammaglobulinemia and

hypogammaglobulinemia which had been detected by electrophoretic studies on patients with severe, recurrent bacterial infections. Agammaglobulinemia or hypogammaglobulinemia occurs in four types: (1) inherited by males as a sex-linked characteristic, (2) acquired for unknown reasons, (3) infantile, due to exhaustion of the maternal supply of gamma globulin before adequate synthesis is established, and (4) secondary, as the result of lymphoma, plasma cell myeloma, etc. The diagnosis can be suspected if the serum globulin is below two Gm. per cent, if isoagglutinins A and B are absent, or if the patient fails to develop antibodies after injection of typhoid vaccine or diphtheria toxoid. A deficiency of gamma globulin is easily discerned by paper electrophoresis. Exact qualification is dependent on complicated immuno chemical techniques which are not readily available. Hypogammaglobulinemia is not considered significant unless the concentration is below 150 mg. per cent. The infantile type of agammaglobulinemia, or hypogammaglobulinemia, usually requires no treatment. The congenital and acquired types require massive, painful, and extremely costly injections at 21 day intervals to maintain a level of 150 mg. per cent. It is suggested, therefore, that treatment with gamma globulin only be used when the diagnosis has been firmly established by quantitative methods. The promiscuous use of gamma globulin "to increase resistance to infection" is considered futile and totally unwarranted.

There were several exhibits on tranquilizing drugs, including chlorpromazine, promazine, prochlorperazine, and ectyluria.

Dinner For Alternate Delegates

Alternate delegates are greatly indebted to Burt Davis, Jr., of California, who, a year ago, arranged for the alternate delegates to have rooms in the official hotel and to have copies of all the resolutions and other agenda to come before the House. This step has made it much easier for the alternates to keep track of the proceedings and to play an active role in reference committee meetings.

This year, Dr. Davis arranged a special dinner which was attended by approximately 70 alternates and wives. Among those honored at the dinner were Dr. Edward M. Gans, who had been designated General Practitioner of the year, Dr. J. Norman O'Neil, of Los Angeles, California, president-elect of the California Medical Society, and the presidents of six other State Associations. The dinner was a delightful and purely social occasion.

House of Delegates*

The House of Delegates of the American Medical Association convened for the first time in its history in Seattle, Washington. A few matters of controversial nature were introduced but so well were they discussed in reference committee meetings that a minimum of debate resulted on the floor of the House. Great credit is due the speaker, E. Vincent Askey of California, for his masterful management of the sessions and for his meticulous attention to details which enabled the machinery of parliamentary democratic procedure to operate smoothly.

PRESIDENT'S ADDRESS

The address by the President, Dwight H. Murray, our guest today, was one of unusual merit and commands the attention of every physician in the United States. Because it will appear in the January issue of our *State Society Journal* I will not discuss it in detail. Suffice it to say that Dr. Murray has appealed to our profession to replace our apathy with a united, active effort to stop the machinations of those politicians who would continue to offer the public something for nothing. Dr. Murray is right when he says that medical freedom is absolutely essential, that every patient should be privileged to select his own physician, and that we as physicians must be free to treat our patients in a manner which we desire. I hope you will read Dr. Murray's address.

GENERAL PRACTITIONER OF THE YEAR

One of the first acts of the House of Delegates was to select Edward M. Gans of Montana as the most outstanding doctor of 1956. Dr. Gans has practiced medicine more than fifty years and at the age of eighty has an enviable record of service to humanity in a section of the United States where rugged individualism, both physical and mental, has been an essential.

PRINCIPLES OF MEDICAL ETHICS

One of the most important matters to be acted upon by the House was the revision of the Code of Ethics. At the Chicago session last June a simplified form of the Code was presented to the House for consideration. With a few minor changes in language this ten point set of principles came up for action. The day-long discussions in the reference committee hearing were instructive and enlightening. Two of the Principles dealing with physician's services and with the source of a physician's income were deemed unsatisfactory because they did not spell out in sufficient detail the prob-

**Presented before the House of Delegates, Connecticut State Medical Society, December 6, 1956.*

lems of fee splitting, corporate practice of medicine, the relationship of patient and physician, and the dispensing of drugs and appliances. For this reason the Principles, which are a condensed form of the old and verbose Code of Ethics, were referred back to the Council on Constitution and By-Laws for further study and reconsideration at the New York session next June.

A resolution to dispense with the Interim Clinical Session was defeated and it was suggested that the Board of Trustees consider holding the winter session of the House of Delegates each year in Chicago while the scientific sessions would be held as now in different geographical locations.

Another resolution was passed which would change the by-laws to protect Service Membership of military reservists who are on extended active duty as medical officers with the uniformed services. The date of reinstatement of members delinquent in dues was extended to June 1, 1957.

WORLD MEDICAL ASSOCIATION

The excellent work of the World Medical Association was pointed out by the chairman of the Board of Trustees, particularly in the field of medical education and in its constructive efforts to aid the physicians in the various countries in maintaining their freedom from government control. This Association is appealing to every physician in the United States to become affiliated and thus aid financially in the support of the excellent work being done by the World Medical Association. Connecticut now has an active committee working in the interest of less fortunate physicians in other parts of the world. At the Seattle session the Board of Trustees of the AMA announced a gift of \$5,000 to be sent immediately to the American Medical Society in Vienna to be used for medical care of Hungarian refugees.

FLUORIDATION

The House of Delegates approved a resolution introduced in its original form by a delegate from Ohio which directed the Board of Trustees to direct the Council on Pharmacy and Chemistry and the Council on Foods and Nutrition to conduct a study of all pertinent presently available information concerning the fluoridation of public water supplies and report to the House at its session in Philadelphia one year hence. The present controversy on fluoridation makes imperative such a study and subsequent action by the House of Delegates.

MATCHING FUNDS FOR WELFARE PROGRAM

The attention of each State Society was called by the Council on Medical Service to the amendment to the Social Security Act which provides for federal funds to be used on a matching basis for medical care for the categorical groups within the welfare program. To quote from the Council report: "This amendment will undoubtedly stimulate the creation of so-called pooled funds and the earmarking of State funds for medical care so as to obtain federal money."

A Guide for Maternal Health Studies was approved. The work of the Committee on Aging was commended but it was noted that there are yet many of the State Societies which have no committee concerned with this subject.

VETERANS CARE

The problem of the care of the neuropsychiatric and tuberculous veteran with nonservice disability was discussed and it was voted to ask each State Society to implement a change in the law whereby only service connected illness of any category shall be entitled to care in VA hospitals.

MEDICARE PROGRAM

The work of the special Task Force on Dependent Medical Care was commended. The Board of Trustees called attention to the fact that "it is obvious that this program through which the federal government is purchasing medical and hospital care from private sources for selected dependents of servicemen carries with it some danger to the private practice of medicine. Constant vigilance will be necessary to prevent any significantly adverse effect on the practice of medicine."

GENERAL PRACTICE

The Progress Report of the Committee on Medical Practices, which was approved, contained a few significant statements. (1) The Committee believes that work on a relative value schedule of fees for the whole of the practice of medicine and surgery should be deferred until it has had an opportunity to confer with representatives of medical organizations throughout the country which have developed such scales. (2) The Committee believes that there is need for a long-term cooperative study of the entire field of general practice on the part of the Council on Medical Education and Hospitals, the Association of American Medical Colleges, the Academy of General Practice, and representatives

of the specialty areas to objectively analyze and make recommendations for consideration as to the best background preparations today for general practice. (3) The importance was stressed of each hospital permitting general practitioners privileges commensurate with their training and demonstrated competence. (4) The AMA representatives on the Joint Commission on Accreditation of Hospitals are to be instructed to see that accredited hospitals do not arbitrarily restrict hospital privileges for general practitioners as a class regardless of their individual professional competence where such policies adversely affect the quality of patient care rendered.

PRERETIRING FINANCING

The Pennsylvania delegation introduced a resolution calling for the study of a preretirement plan of health insurance for retired persons produced by their State Society. This is a seven page document and was referred to the Board of Trustees for further study.

VA HOSPITAL BILLS

The House approved two resolutions condemning the practice of some full time VA physicians as well as some part time physicians in VA hospitals who are rendering bills to patients who are covered by Workmen's Compensation Insurance or by private medical insurance. The practice of some VA hospitals who are rendering bills for hospital care to patients in the same category was also condemned.

BLUE SHIELD PLANS

Approval was voiced of the efforts of Blue Shield plans to extend benefits to the fullest extent commensurate with actuarial soundness and physicians were urged to participate actively in such plans which are sponsored by medical groups.

HOSPITALIZATION OF ALCOHOLIC PATIENTS

The Council on Mental Health made a strong appeal through the Board of Trustees for the proper care of the patient with acute alcoholic intoxication as a medical emergency. This Council believes that the type of alcoholic patient admitted to a general hospital should be judged on his individual merits. The entire viewpoint and attitude which places the alcoholic in the category of a sick individual is changing. Hospital staffs should be urged to accept these patients for treatment, particularly as it increases the completeness of the training afforded house officers. This report was approved

and called to the attention of the Council on Medical Education and Hospitals.

ESSENTIALS OF APPROVED RESIDENCIES

The Council on Medical Education and Hospitals brought in new essentials for Aviation Medicine and some modification of the essentials for Occupational Medicine. These were adopted. A revision of the current essentials of an approved residency in radiology were also approved. These call for a three year training program in all divisions of the specialty; diagnostic roentgenology, therapeutic radiology, including the use of radioactive substances (intercavitary and interstitial), and isotopes.

APPROVAL OF HOSPITAL RESIDENCIES AND INTERNSHIPS

A resolution introduced by the Indiana delegates was adopted requesting the Council on Medical Education and Hospitals "to urge each specialty board to give a minimum of six months notice to each educational institution and/or hospital of any intended withdrawal or downgrading of an approved program, giving the institution an opportunity to correct such deficiencies that exist and giving the representatives of that institution an opportunity to be heard with respect to the suggested changes." The withdrawal or downgrading of approval would be effective at the end of this designated period if the deficiencies had not been corrected.

INTERN SHORTAGE

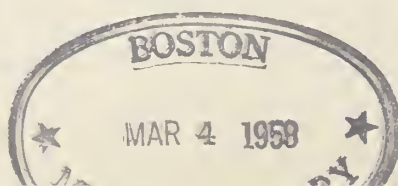
An attempt was made to disapprove the "25 per cent rule" of internships but this failed. The House did adopt a resolution calling for reapproval of the principle of voluntary reduction in the self assigned quota of interns as printed in the 1956 Handbook of the National Intern Matching Program, Inc.

PEOPLE-TO-PEOPLE FRIENDSHIP PROGRAM

The House approved a resolution introduced by the Oklahoma State Medical Association which pledged "full support of our initiative and energy to a people-to-people program as a means of promoting understanding, peace, and progress" and "to gain sympathetic understanding of the thoughts and feelings of other peoples that we may work for a true friendship with them in a happier, friendlier, and more peaceful world."

MEDICAL ASSISTANTS ORGANIZATIONS

The House commended "the objectives of the American Association of Medical Assistants and its



sincere desire to work closely with the medical profession in improving medical service and medical public relations."

RADIOACTIVE ISOTOPES

Over the objections of Dr. E. P. Pendergrass, Section on Radiology, the House voted approval of a policy of the AMA with reference to the use of radium and artificially produced radioisotopes as follows: (1) In any hospital in which a patient is to receive radium or the products of radium or artificially produced isotopes, there should be a duly appointed committee on "radium and artificially produced isotopes" of the hospital professional staff. This committee should include, but not necessarily be limited to, the following qualified physicians: (a) a radiologist, (b) a surgeon, (c) an internist, (d) a gynecologist, (e) a urologist, (f) a pathologist. This committee should have available such competent consultation of other physicians and scientific personnel as may be required by it.

(2) In any hospital, the use of radium or its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes shall be restricted to qualified physicians so judged by the Committee on Radium and Artificially Produced Radioisotopes of the professional staff to be adequately trained and competent in their particular use.

(3) It is recommended that procurement, storage, and inventory of all radioactive isotopes for the use of the hospital staff and radiological therapy control be centralized and, where administratively possible, centralization be located in the Department of Radiology.

(4) Board of Trustees is to assign to the proper committee or Council of the AMA the further study of isotopes for diagnosis or therapeutic use.

AMERICAN MEDICAL EDUCATION FOUNDATION

In 1955 the AMEF transferred to the medical schools through the National Fund for Medical Education \$1,120,429 to make a total of \$4,684,312 distributed since 1951. For the first six months of 1956, \$439,160 was added to the above. This figure does not include the \$100,000 gift from the AMA voted at the Clinical Meeting in Boston one year ago nor does it include \$130,000 which the California Medical Association contributed this year. In addition to the California gift, three other State Societies

presented contributions at the Seattle session as follows: New Jersey, \$25,000; Utah, \$11,870; and Arizona, \$3,695. Hereafter donations by AMEF will go directly to medical schools and not through the National Fund. Special notice was given to Connecticut with five other State Societies which have actively organized committees at the local level, resulting in outstanding increases in the number of individual contributors.

MISCELLANEOUS

The House of Delegates instructed the Board of Trustees to accentuate cooperation between the American Medical Association and the American Bar Association to the end that a bill of the Jenkins-Keogh type be enacted at the next session of Congress.

At the opening session Dr. Murray, on behalf of the American Medical Association, presented a special citation to Ciba Pharmaceutical Products, Inc., for "the service it has performed to the medical profession and to the nation through its weekly television series, 'Medical Horizons'."

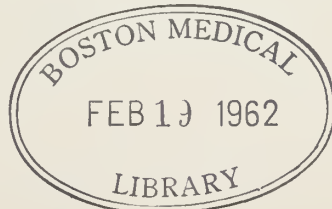
CONNECTICUT AT SEATTLE

In spite of the fact that the Seattle airport was shut down for over two days due to fog, necessitating long bus rides for many from Portland, Oregon, Spokane and Everett, Washington, all the Connecticut delegates and alternate delegates were on hand for all the sessions. The total registration was 6,282 of whom 2,813 were physicians from almost every State and several foreign countries.

News From Yale University School of Medicine

Lytt I. Gardner has been appointed professor of pediatrics at the Yale School of Medicine, effective in November, 1956. Dr. Gardner comes to Yale from the State University of New York, College of Medicine, Syracuse, where he was professor of pediatrics.

Max Taffel, associate clinical professor of surgery, received the Francis Gilman Blake Award for 1956. This award is sponsored by the Yale Chapter of Nu Sigma Nu and is presented annually to the faculty member chosen by the graduating class as the most outstanding teacher of the medical sciences.



REPORT OF THE CHAIRMAN OF THE COUNCIL

C. LOUIS FINCKE, M.D., *Stamford*

Mr. Speaker, Mr. President, and Members of the House of Delegates:

As the Society grows, the work of the Council expands both in quantity and importance. The committee reports which are printed in the agenda, or which will be read to you today, bear witness to the manifold and diverse activities of your Society. The Council, acting as the executive committee, must be familiar with, accept, approve or disapprove, reports from nearly all committees. It must make appointments, accept resignations, or present nominations for membership on all these committees; it must formulate and approve a budget for your consideration; it is charged with the responsibility of operating the Society's affairs, its building at New Haven, of arranging joint conferences with allied professional groups, of supervising through its committees the legislative program relating to matters of health, the Clinical Congress, meetings of this House of Delegates. This is the type of activity commonly labeled "routine business." If interested you can find it reported regularly in the *STATE MEDICAL JOURNAL*.

Periodically and with increasing frequency certain matters come to the Council that can by no means be considered routine. One such matter has appeared on the scene suddenly. I refer to the *MEDICARE* Program. The Act of Congress, signed by the President in June, providing for the medical care of the dependents of uniformed personnel residing in the State, is to go into effect December 7. This deadline allowed precious little time for implementing and administering an enormous project. In the briefest form I report herewith what has taken place.

Following the enactment of the bill, the Defense Department communicated with the AMA which in turn summoned a conference between a Task Force of the Defense Department, representatives of the AMA and of each State Medical Society. Fortunately Connecticut was represented by that most competent negotiator, the versatile and peripatetic Dr. Creighton Barker. Following his return from Chicago, a special meeting of the Council was called in August. At that meeting the Council voted without dissent that:

1. The Connecticut State Medical Society will co-

operate in any reasonable way with the Department of Defense in planning, negotiating and operating the medical-surgical phases of the *MEDICARE* Plan in Connecticut.

2. The Society requests the Department of Defense to name Connecticut Medical Service as a contracting agent, to administer Medical Surgical Services in Connecticut.

3. As soon as practicable after receiving from the Department of Defense the official coded nomenclature of services to be rendered, the Society will prepare a schedule of fees to be paid for those services in Connecticut and submit this fee schedule to the Department of Defense.

4. The president of the Society, the chairman of the Council and the executive secretary to be empowered to appoint a Committee to include a representative from each County Association, at least two members of the Council and representatives of appropriate specialties. This committee shall be charged with the development of the fee schedule mentioned in 3 above, and serve in continuous liaison with the Connecticut Medical Service and the Council of the State Medical Society in overseeing the medical professional operation of the plan.

5. The executive secretary shall serve as the coordinator of the plan.

6. The executive secretary shall communicate these actions of the Council promptly to Dr. George F. Lull, secretary and general manager of the American Medical Association.

It may seem to you as it did to us on the Council, that this was a major decision for the Council to make on behalf of the Society. But we were given little choice. The program had to be accepted by September 1, and a preliminary fee schedule formulated forthwith. Failure to do so would mean the Department of Defense would itself step into the breach, set up its own machinery for administering the program and establish its own fee schedule. This alternative appeared dismal indeed.

Following the Council's action a committee was appointed. It included members of the Council and representatives of each County Association and the principal specialties. At an emergency meeting of

Presented before the semi-annual meeting of the House of Delegates, Hartford, December 6, 1956

this committee, which incidentally was attended 100 per cent, a preliminary fee schedule for some 200 procedures was established and forwarded to the Department of Defense. Schedules for more than 2,000 additional procedures have subsequently been filed subject to renegotiation. On authorization by the Council the executive secretary and Dr. Thomas Danaher of the Council and president of CMS were authorized to meet in Washington with the Task Force of the Defense Department to negotiate for the approval of CMS as the contracting agent and to present the fee schedule approved by the committee mentioned above. One or both of these gentlemen can explain further on the course of events at that meeting and subsequent developments. I ask your approval and ratification of this action of the Council.

The other matter of major importance that I wish to report today is now making its third appearance before this House. It has to do with the implementation of the resolution passed by this body on recommendation of the Committee on Hospitals. On December, 1955 and in May, 1956 reports on the Council's efforts were presented to you. They were progress reports. The report this time also is a progress report, but it is a matter of some chagrin that little progress indeed has been made. As you know from preceding messages, a special subcommittee of the Council to implement this directive has been functioning since the resolution first came to the Council for action. Expert legal opinions have been secured on the interpretation of the Medical Practice Act and diametrically opposed conclusions reached. The more discussion and investigation by this special subcommittee, the more complicated the problem appears to be. A study of the Medical Practice Act reveals that it was written in 1893, and although it has been amended subsequently on various occasions, it is still geared to a system of practice of medicine that is 60 years old. The best legal opinions seem to indicate that nonprofit hospitals may employ physicians to render professional service, and charge a fee for this service which the hospital collects. A tacit corollary to this opinion is that no organization except a nonprofit hospital has such privilege. If this is so, where then does the law point in regard to industrial medicine? May industry hire a physician whose services are dispensed to its employees? What is the legal position of third parties—be they government, lay-sponsored, commercial insurance or physician-sponsored plans?

Are many of our members practising medicine well outside the best legal interpretation of the Medical Practice Act of 1893? If we suggest rewriting the Medical Practice Act to spell out in detail the methods by which physicians may practice, can we persuade our legislators that it is not for the benefit of the doctor? Surely if the question comes up at all, many public groups may oppose the proposals of our profession. If any change is contemplated obviously it must be presented convincingly as of benefit to the patient and in the best public interest. Will it be possible to demonstrate convincingly the advantages to the patient of the time honored private physician-patient relationship?

As you see, the problem of hospital-physician relationship has unexpectedly developed many ramifications that extend well beyond the original purpose of the resolution and of the committee appointed to implement it. The matter now invades the territory of other committees such as the Legislative Committee, the Committee on Third Party Payments and the Public Relations Committee. Doubtless others will ultimately be involved as the problem unfolds. In fact, the whole philosophy of the practice of medicine of the future is at stake. The subcommittee of the Council that has been working on this complex problem has recently been augmented, primarily for exploratory purposes. It is contemplated that this larger committee will investigate in detail the various ramifications noted above and doubtless will confer with other committees where overlapping occurs. An attempt to delegate each aspect to the proper group will be made in the months to come.

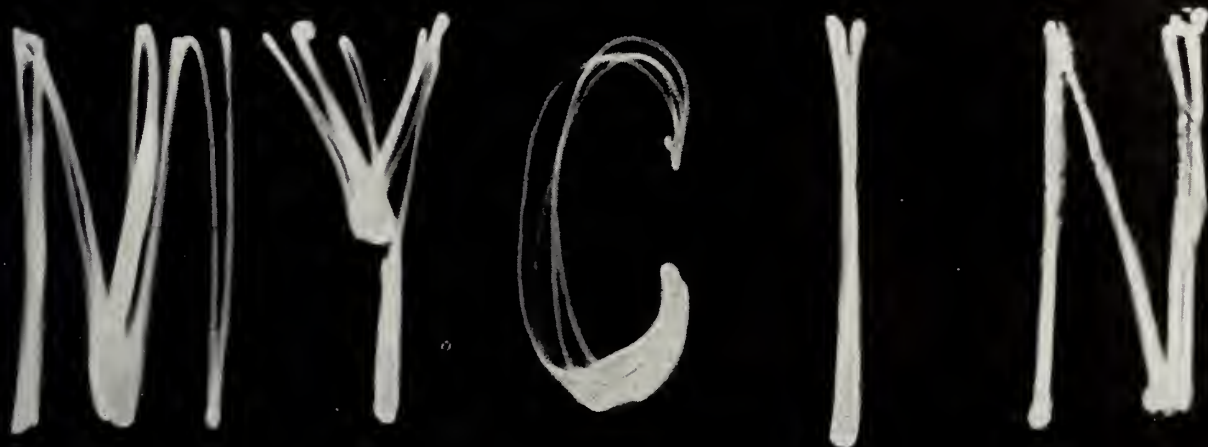
I therefore ask your indulgence for another six months and that you accept this as a further progress report on this subject.

Many of you have seen, and I hope many more will soon visit, the new wing of the Society's building in New Haven. It is our building and should be a source of pride to each of us. We live in one of the most prosperous communities in the world. The benefits which accrue to us from this geographical good fortune impose a corresponding obligation. We are and must continue to be among the leaders of State Medical Societies. Our building is symbolic of the progressiveness and initiative of our members. Those who do not share in the support of our activities and our building penalize both themselves and the Society. I am sure the physicians of Connecticut will not shirk their proud responsibility.

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REPORT OF THE COMMITTEE ON THIRD PARTY PAYMENTS TO THE HOUSE OF DELEGATES AT ITS SEMI-ANNUAL MEETING DECEMBER 6, 1956

WILLIAM H. CURLEY, M.D., *Bridgeport*

At the annual meeting of the House of Delegates of the Connecticut State Medical Society on April 24, 1956, three recommendations were adopted that pertained to this Committee.

The first of these was to "complete the task of preparing a statement of policy for guidance of the members of the Society in meeting the problems of third party payments." It is planned to report on this matter at the next annual meeting of the House of Delegates.

Before presenting the conclusions of this committee in regard to the other two recommendations of the House of Delegates, we wish to review the existing relationship between the Connecticut State Medical Society and the Connecticut Medical Service.

Connecticut Medical Service, Inc., is a completely independent Connecticut corporation operated by a Board of Directors composed of six physicians and six laymen. The six physicians are nominated by the Council of the Connecticut State Medical Society. The six laymen are nominated by a nominating committee appointed by the president of CMS. This nominating committee consists of one layman and one physician. All directors are appointed for one year terms at the annual meeting of CMS. There is an executive committee of the Board of Directors which employs an executive director who is in general charge and management of this corporation, subject to its direction. The executive committee also employs a Director of Medical Services whose appointment is recommended by the Professional Policy Committee of CMS.

1. The Professional Policy Committee is the policy initiating body of CMS. To date, no recommendation of the Professional Policy Committee has been disapproved by the Board of Directors of CMS upon whom the ultimate legal responsibility for the administration of CMS rests. The enabling act which established CMS, however, provided that CMS contracts and operations must be approved by the Insurance Commissioner of the State of Connecticut.

2. At this time, the Professional Policy Committee of CMS is composed of 12 members. The chairman

of the Professional Policy Committee is appointed by the president of CMS. The President and President-Elect of the Connecticut State Medical Society are members of the Professional Policy Committee by virtue of their office. Six members of the committee are nominated directly by the Council of the Connecticut State Medical Society. The remaining three members are nominated by the County Medical Associations and elected on a statewide ballot by all Participating Physicians.

3. The Council of the Connecticut State Medical Society is made up of county councilors, their alternates and the elected officers of the Connecticut State Medical Society. The county councilors and their alternates are elected directly by the respective memberships of the County Medical Associations. The officers of the Council are elected by the House of Delegates. The Council is charged with the administration of affairs of the Connecticut State Medical Society subject to the House of Delegates and employs an executive director and staff for this purpose.

4. In short, then, it is difficult to see how two separate entities could be more closely interwoven without making them one.

5. The second recommendation included the words, "that in the future, when changes in contracts are contemplated by CMS, adequate opportunity for study by the entire membership of participating physicians should be afforded and due consideration given to an expression of the minority."

6. It is the opinion of this committee that to provide adequate opportunity for study of all contemplated CMS contract changes by the entire Participating Physician membership is unrealistic, impractical and unworkable. However, when an opportunity to study major contemplated changes can be afforded the Participating Physician by CMS without impairing the efficiency of CMS's operation, it should be done. Lacking this opportunity, it is suggested that the Professional Policy Committee inform a designated committee of this Society of any contemplated changes for its comments.

Presented before the semi-annual meeting of the House of Delegates, Hartford, December 6, 1956

7. The third recommendation of the House of Delegates was, "to consider an approved method of referendum and an approved method of membership on the Professional Policy Committee in order to express more adequately the opinions of the entire membership."

8. It is the opinion of this Committee that the mailing of preliminary proposed major changes in CMS contract to the Participating Physicians for their individual comments at the discretion of the Professional Policy Committee and when time and other factors permit, would be beneficial to both CMS and the Participating Physicians. It is also suggested that any future referendum be tabulated by geographical and specialty distribution. This committee did not feel that the orderly conduct of business by CMS should be handicapped by rigid requirements in this regard. The past record of CMS in its relations with the Connecticut Medical Society should not be overlooked and this committee feels that close cooperation can be expected in the future.

9. This committee suggests that the following changes in the composition of the Professional Policy Committee might broaden the geographical and specialty representation of that committee.

(a) The President and President-Elect of the Connecticut State Medical Society should no longer be members of the Professional Policy Committee by virtue of their office.

(b) Four members of the Professional Policy Committee should be elected for two year terms as at present, two of these to be elected each year and the specialty representation to be specified by CMS.

(c) Eight members of the Professional Policy Committee should be appointed by the Council for one year terms. The Council would be expected to pay particular attention to fair geographical and specialty distribution of these appointees.

(d) The Chairman of the Professional Policy Committee to be appointed by the President of CMS from the 12 members of the Professional Policy Committee.

OUR MEDICAL WORLD

The World Medical Association

The new president of the World Medical Association elected at the 10th General Assembly in Havana, Cuba in October, 1956 is Dr. Jose A. Bustamante of Cuba. Dr. Alimet Rasim Onat of Turkey was chosen president-elect. From the United States Gunnar Gundersen was elected to the Council and Austin Smith as chairman of the Editorial Board. The Council appointed Dr. Smith as executive editor and Louis H. Bauer as business manager of the *World Medical Journal*.

The New Zealand Branch of the British Medical Association was elected to membership in The World Medical Association at the 10th General Assembly in Havana, Cuba, October 9-15, 1956. This association was organized in 1896 and has approximately 810 members.

The following are among numerous resolutions adopted by the 10th General Assembly of The World Medical Association:

INTERNATIONAL MEDICAL LAW

"It is the primary function of the medical doctors of the world to formulate any code of International Medical Law and The World Medical Association is the only organization that can speak for the doctors of the world."

TRAFFIC ACCIDENTS

"Whereas: The death and maiming of humanity throughout the world is increasing rapidly each year; and

"Whereas: It is the duty and responsibility of the medical profession in every country of the world to assist in the preservation and maintenance of human life;

"Therefore, be it resolved: That The World Medical Association recommend to its member associations that they cooperate with other agencies and authorities within their country to whatever degree is possible and necessary in a concentrated endeavor to save and preserve human life."

FROM OUR EXCHANGES

A reported cure of acute staphylococcal bacteremia (even one case) is interesting, particularly the procedure employed (Nordland and Borden, *Quar. Bull. Northwestern Univ. Med. Sch.*, 30:2, pp. 133-137). The staphylococcus responsible for infection demonstrated a high degree of in vitro resistance to streptomycin, erythromycin, and the tetracycline derivatives, but was moderately sensitive to chloramphenicol and highly sensitive to bacitracin. Concentrations of penicillin and bacitracin together were bacteriicidal at lower levels than was either agent alone. Surgical drainage of a tissue abscess was essential in bringing the infection under control. The giving of antibiotics in combination and in large doses was based on laboratory studies. The article contains a brief discussion of the factors involved in the emergence of resistant strains of staphylococcus. The high mortality rate of staphylococcus bacteremia is alluded to briefly.

* * * *

Meade and Weinstein (*Boston Med. Quart.*, 7:2, pp. 35-41) declare in a study of "The Treatment of *H. influenzae* Meningitis" that "when compared to the therapeutic results produced by chloramphenicol or chlortetracycline, the use of sulfonamide plus streptomycin (intramuscular and intrathecal) appear to be the regimen of first choice in the management of infection of the meninges produced by *H. influenzae*."

* * * *

Cuadra points out that acute bartonellosis (Oroya fever) is frequently complicated by a severe complication of septicemic type caused by salmonella. Bartonellosis may be seen in three forms: (1) febrile acute anemia, not followed by verrucous eruption; (2) febrile acute anemia followed by verrucous eruption; and (3) verrucous eruption not preceded by febrile acute anemia. It is this last form that is most commonly seen. The high mortality rate of acute bartonellosis is due to the secondary infection which commonly occurs during the convalescent stage, that is, during the period of recovery from anemia; and is usually due to the salmonellas (*Tex. Report Biol. Med.*, 14:2, pp. 97-113).

Uncomplicated Oroya fever has a good prognosis.

About 40 per cent of the cases are complicated by salmonella (commonly *Salmonella typhimurium*) and here the deaths occur in 90 per cent of the cases. Chloramphenicol is greatly effective against the grave danger of salmonella complication.

* * * *

"Respiratory Disease in Recruits" is of special interest in these days of the draft (*U. S. Armed Forces Med. Jour.*, VII:7, pp. 937-962). Duff points out that common respiratory diseases are an important cause of recruit noneffectiveness. The peak in continental United States occurs during the winter months. There is an excessive rate during mobilization. There is a suggestion in the army experience of a definite seasonal and geographic effect upon the reported incidence of these diseases. The highest incidence was reported during the first three or four months of service. It is concluded that under favorable geographic and seasonal conditions large recruit populations may be assembled, trained and become seasoned without epidemics of common respiratory disease.

* * * *

"The Treatment of Cancer of Thyroid Gland" has a continuing interest for most practitioners of medicine (*Calif. Med.*, 84:6, pp. 381-387). Garland is of the opinion that the optimum treatment of cancer of the thyroid depends on the pathological type of tumor present and the stage of the disease. Practically speaking the well differentiated papillary carcinoma is adequately treated by a simple operation. In other types of thyroid cancer a more extensive operation is indicated, followed by adequate postoperative radiotherapy.

In terms of the clinical stages the primary treatment of most cases classified as stage I and II should be surgical; and most cases classified as stage III and IV should be radiological. There seems to be plenty of room in this classification for common sense and good judgment.

The five year survival rate in the author's series of nondetermined cases treated under the outlined plan was 47 per cent. Persistent treatment of selected inoperable cases or metastatic lesions may result in an unexpectedly long survival.

Barach (*Jour. Amer. Geriatric Soc.*, IV:6, pp. 517-525) in a "Study of the Pathogenetic and Allied Influences in Chronic Emphysema" is of the opinion that a program dedicated to physical and mental rest is fraught with hazard. Muscular atrophy, bodily unfitness and loss of pulmonary reserve are the result of unwarranted reduction of physical exercise.

As the result of advances in many fields of medicine that have application to these patients with early and moderately advanced form of the disease, a good deal of reversible pathology is possible. Such patients should be encouraged to participate in stimulating activities in their local society to the limits their personality permits. The heart of the matter is the physician's attitude. The complexity of the effects of exertion and hyperventilation on physiologic function of the lung represents a challenge to the doctor's best effort.

* * * *

Perhaps the conclusions of Goldner in his discussion of "Obesity and Its Relation to Disease" are no surprise to most physicians. He makes the following observations: (1) Obesity is accompanied by a shortened life expectancy. There is a morbidity rate for degenerative cardiovascular disease, diabetes and biliary diseases. (2) Obesity aggravates pre-existing and independently developing disease. (3) The high fat content rather than the high caloric content of the diet may contribute to the development of degenerative vascular disease in obesity. (4) Dietary restrictions and exercise are the only treatment of obesity. Patients need emotional support to adhere to a reducing program (*N. Y. State Jour. Med.*, 56:13, pp. 2063-2069).

* * * *

"An Evaluation of Twenty Two Patients with Acute and Chronic Pulmonary Infection with Friedlander's Bacillus" is offered by Limson *et al.* (*Ann. Int. Med.*, 44:6, pp. 1070-1080). Nine of thirteen patients with acute Friedlander's pneumonia died. One of the nine in the chronic group died. In vitro sensitivity tests Friedlander's bacillus is usually sensitive to the tetracycline group, chloramphenicol and streptomycin. In practice a combination of streptomycin and one of the tetracycline group or chloramphenicol may be the treatment of choice. Therapy should be initiated on the slightest suspicion of this condition.

* * * *

Moser *et al.* in a discussion of "Drug Therapy of Hypertension" conclude that antihypertension drugs appear to be indicated in most cases of complicated hypertension (*N. Y. State Jour. Med.*, 56:16, pp. 2487-2496). Some cases of rapidly progressive hypertension may be reversed by adequate continuous therapy.

Mecamylamine is a new potent ganglionic blocking agent. It is nearly completely absorbed when given orally. Approximately 25 per cent of cases with severe hypertension appear to have achieved excellent response to date on Ansolysen or Mecamylamine in combination with Apresoline and/or reserpine. An additional 90 per cent of cases have a significant blood reduction.

An opinion regarding the prognosis of cases on drug therapy is not justified at the present time.

* * * *

"The Child in the Maladjusted Household" has been the subject of centuries-old, intense discussion. Craig (*Practioner*, 177:1057, pp. 21-32) points out that today starvation and poverty are rare but that children still often lack a sense of security and confident happiness in too many homes.

Publications dealing with behavior disorders in children commonly give scant reference to the work of the family doctor. It is possible for the family doctor to make a major contribution to this problem by virtue of his intimate knowledge of families in their practice.

Social measures aimed at correcting behavior disorders of children too frequently attempt to apply the correction despite the home background. Allowing that a proportion of cases do require specialized investigation and management, no child should be referred unnecessarily to the hospital or special clinic. The family doctor with interest, patience, and time can secure results in many cases of juvenile delinquency by recognizing and assisting to dispel causes of maladjustment in the home.

Most children are at some time or other a cause of parental anxiety. If there is no organic basis and if the misbehavior arises from maladjustment within the household, it is misleading to label them as maladjusted children. To do so is to ignore the source of the trouble. Management of these cases consists largely, and sometimes solely, in rectifying influences within the home—influences which the family doctor is in a position to recognize and often to remedy.

(Continued on page 63)

NEWS FROM WASHINGTON

Medicare in Operation

A new venture in federal medical care—the armed forces dependents medical care program—was launched on schedule December 7, and 2 million dependents of servicemen became eligible for hospitalization and extensive medical care.

The MEDICARE program, because it is a pioneer effort, will be watched closely by members of Congress, the armed services and the medical profession. Congress will be interested in keeping track of the cost of the program as well as the availability of care.

The Defense Department has earmarked \$41 million for the program through next July 1. Thereafter it is estimated the cost will run between \$60 million and \$70 million a year. When the program is operating at its peak, as many as 800,000 dependents not now getting care at U. S. expense are expected to be participating.

In all but a few States, provision of medical care outside military facilities is being made under agreements signed between the state medical societies contracting agent (generally Blue Shield) and the Army which is the executive agent for Defense.

The contracts run for seven months, and all States are expected to renegotiate contracts prior to their expiration next July 1. New contracts naturally would reflect the experience gained since December 7.

As the vast new project went into force, the newly created Office of Dependents Medical Care (ODMC) stressed that the law intended that civilian medical care under the program should be comparable to that provided in armed services facilities. Participating physicians receive payment in full from the government under a published schedule of allowances. ODMC said this means that the doctor will receive payment for his usual charge or the amount set in the schedule whichever is less.

ODMC made these additional points:

1. In instances in which the physician believes that an allowance greater than that prescribed in the local schedule is justified, he should look to the government rather than the patient for payment. Provisions have been made for him to submit a

special report to his state medical society and, the society, in turn, to the government.

2. Military dependents may submit as identification their post exchange card, the combined post exchange-commissary-military medical care card, or the standard military dependent identification card. A special MEDICARE card is being prepared, and after next July 1 will be the only identification allowed for this purpose.

3. There are no plans in Defense for authorizing payments for drugs, medicals or other medical supplies, except those furnished while hospitalized or those administered directly by a physician.

4. The claim form to be used by physicians in the MEDICARE program is called "Statement of Services Provided by Civilian Medical Sources." ODMC said sufficient supplies have been furnished by all State agents.

5. The law and implementing regulations do not permit payment for any medical care, services or hospitalization prior to December 7; this includes prenatal care.

Proposals for 85th Congress

The broad outline of legislative proposals to come from the administration in newly convened 85th Congress was first sketched by HEW Secretary Folsom in several appearances before newsmen in December. Among them are: (1) federal grants to medical schools for teaching facilities, (2) authorization for smaller insurance companies to pool resources without violating the antitrust laws in effort to encourage expansion of voluntary health insurance, (3) increased attention to problems of older persons, particularly in health and adult education, (4) continued expansion and improvement in vocational rehabilitation, and (5) expansion of staff and facilities of the Food and Drug Administration.

Extension of Salk Vaccine Grants Urged by Health Officers

State and territorial health officers have recommended continuation for another year of the Salk polio vaccine grants program now scheduled to expire next June 30. This is the program under which

the government gives the States money to aid in setting up inoculation programs. The first year \$30 million was made available, and this year the total is \$23.6 million.

The state health officers' endorsement, made at the windup of their 55th annual meeting with the surgeon general of the Public Health Service and the chief of the Children's Bureau, was the first public backing for continuation of the program. President Eisenhower may have something to say on the subject in January when he outlines health objectives of the administration.

Other recommendations of the health officers: (1) extension of Hill-Burton hospital construction program for another five years beyond June 30, 1958, with continuation of the \$210 million authorization for hospitals, clinics and nursing homes, (2) doubling appropriation and authorized ceiling for water pollution control construction grants, (3) development by PHS of bills for prevention and control of chronic disease and health promotion of the aged, including State grant-in-aid program, and (4) promotion by PHS of a bill to allow PHS to cooperate with communities in building hospitals for both Indians and non-Indians.

Institute Makes First Awards in Cerebral Palsy Study

First awards have been made in the Public Health Service's research program in cerebral palsy and mental retardation. Yale University School of Medicine has received \$107,799, and Brown University was granted \$97,633. The study which will cover a 10-20 year period, will attempt identification of factors responsible for cerebral palsy, mental retardation, blindness, and deafness. A complete family history, pregnancy and prenatal histories, and an account of events at birth will be collected for each child studied. Follow-up examinations will be made periodically on infants who show signs of stress or defects in development. The National Institute of Neurological Diseases and Blindness will analyze all data obtained.

United Nations Statistician to Head Sickness Survey for PHS

The new national survey of illness and disability in the U. S. authorized by the last Congress will be directed by Forrest E. Linder, PH.D., chief of the United Nations demographic and social statistics

branch. He received his degree from Iowa State University, served in the Navy during World War II where he had technical responsibility of reorganizing medical statistics and prior to going to the U.N., served as deputy chief of the National Office of Vital Statistics.

The last previous federal survey that comes anywhere near the project planned under the law passed by the last Congress was in 1936. Surgeon General Burney said data to be obtained each year will be "of great value to all public and private agencies working to advance the Nation's health." PHS plans to use scientific door-to-door sampling techniques similar to those developed by public opinion polls.

Defense Outlines Rules in Osteopath Commissioning

The Defense Department has issued a directive outlining policy in the commissioning of osteopaths in the military services, a law passed by the 84th Congress. An osteopath must meet the following requirements, among others:

- 1st. Be a graduate of a college of osteopathy whose graduates are eligible for licensure to practice medicine or surgery in a majority of the States, and be licensed to practice medicine, surgery or osteopathy in one of the States, territories or the District of Columbia.
- 2nd. Possess such qualifications as the secretary concerned may prescribe for his service after considering the recommendations for such appointment by the surgeon general of the Army, Air Force or Navy.
- 3rd. Have completed a minimum of three years college work prior to the entrance into a college of osteopathy, plus a four year course with degree of doctor of osteopathy in a school approved by the American Osteopathic Association, and a year internship or residency training approved by the AOA.

PHS Center to Promote Research in Problems of Aging

Promotion of research in the problems of the aging population is the objective of a new Center established by Public Health Service. To be known as the Center for Research on Aging, the new unit will be under direction of the National Institutes of Health at Bethesda and will be headed by Dr. G. Halsey Hunt, presently associate chief of the PHS Bureau of Medical Services. He took the post November 19.

Through the Center PHS will offer financial support to universities and other organizations for research on medical problems of the aged. An initial step will be to encourage nonfederal institutions to set up permanent centers to do research on aging. PHS will offer the grants to help meet expenses.

Dr. Kenneth R. Nelson is being shifted from head of the PHS hospital at San Francisco to succeed Dr. Hunt as associate chief of the Bureau of Medical Services. The San Francisco post will be taken over by Dr. Donald W. Patrick, whose assignment as head of the PHS Clinical Center at Bethesda goes to Dr. Jack Masur. Dr. Masur's appointment was announced recently.

February Call for Physicians Placed at 450

Selective Service plans to call up 450 physicians next February, 250 of them for the Army and 200 for the Air Force. This is the largest single call since the Army, Navy and Air Force took 1,275 men in March, 1955. The following month Congress started hearings on the doctor draft extension bill. The act is scheduled to expire next July 1, and the Defense Department has indicated it would not ask for another extension. The draft call prior to the latest one was for 300 men in October. Other calls this year were 297 in February and 380 in July.

In announcing the call, Selective Service directed local boards to comb their files to make sure that younger priority 3 physicians in residency training who have been deferred are really essential to the operation of hospitals. Some of these, said Selective Service, are not essential but are so classified. "It is hoped that there is yet time to get a sufficient number of younger men reclassified into class 1-A to satisfy these proposed calls without going into the upper age bracket," a memorandum to boards stated. By younger men, Selective Service means those under 37 years.

Since the program went into effect in 1950 at the time of the Korean War, the special draft has brought 10,337 physicians into the services.

Labeling Rules Issued for Cobalt Compounds

Food and Drug Administration has promulgated rules governing use of hemopoietic drugs containing cobalt salts. Action has been taken because, to quote FDA, "the present state of scientific knowledge concerning the use of cobalt salts as hemo-

poietic agents is limited, in that the mechanism of their action is not known and the possible deleterious effects of prolonged administration have not been fully determined."

"By prescription only" is the new rule for preparations containing a per dosage unit exceeding 10 mg. of cobalt chloride, or more than 2.5 mg. of cobalt in any form of salts. Labeling shall caution and guide physicians as to toxicity and possible adverse effects and as to indications for simultaneous administration of iron salts for maximum effectiveness.

Where per dosage unit is less than 10 mg. of cobalt chloride, or less than 2.5 mg. of cobalt in any form of salts of cobalt, over-the-counter sale will be permitted for treatment of simple iron deficiency anemia only, provided that certain labeling conditions are met. These deal with limitation of intake per 24 hour period, avoidance of prolonged use unless directed by a physician and denial of administration to children under age 12 except on authorization by the physician.

Federal Service Loses Dr. Eliot to Harvard

Dr. Martha Eliot's resignation as chief of Children's Bureau to join Harvard's faculty of Public Health was viewed as "a matter of deep personal regret" by Secretary Marion B. Folsom of Health, Education and Welfare. "She has shown imagination, energy, courage and great ability," he declared. "As chief of the Children's Bureau for the past five years, Dr. Eliot enhanced the tradition of that Bureau in keeping the nation sensitive to the needs of children."

Effective January 1, the 66 year old Dr. Eliot will become professor and head of Department of Maternal and Child Health at Harvard's School of Public Health. Only two other women now hold full professorships at Harvard: Cora DuBois, anthropologist, and Cecilia Payne-Gaposchkin, astronomer.

A Johns Hopkins medical graduate (1918), Dr. Eliot has been in Federal service continuously since 1924, except for a two year period (1949-51) when she was assistant director general of World Health Organization. She was one of the architects of the UN's International Children's Emergency Fund (UNICEF) and was president of American Public Health Association in 1947-48. At Harvard, she will succeed to the position held since 1927 by Dr. Harold Coe Stuart.

Births in 1956 Will Be 4.2 Million, a New High

National Office of Vital Statistics, in USPHS, estimates that country's birth total this year will approximate 4,202,000. This would set an all-time record for numbers. Previous mark was the 4,091,000 of last year. If prediction for 1956 is fulfilled, birth rate would be 25.1 per 1,000 population—highest on record except for the 26.6 in 1947 and the 25.3 in 1954. This year's increase over 1955 is attributed both to a rise in number of couples having their first child and to a rise in subsequent births. For the past several years, USPHS has noted steady increases in birth rates of third, fourth and fifth children in families.

Mr. Hendricks Takes New Post as Field Director

The AMA Board of Trustees announced the appointment of Thomas A. Hendricks, who has been serving as secretary of the AMA Council on Medical Service, to the newly created position of field secretary.

Mr. George Cooley, who has handled much of the Council's heavy load of work as associate secretary, was named acting secretary of the council.

Tom will serve in a two-way communications job: 1. As field representative from the secretary's office in Chicago headquarters, he will interpret AMA policies and programs for state and county medical societies; 2. By virtue of his accessibility in the field, he will be an important link in the communications chain between state and county medical societies and the AMA. Through him another avenue is available for transmitting to AMA headquarters and the Board of Trustees up-to-the-minute reports on local problems and attitudes.

Mr. Hendricks has had a long career in the field of medicine. Before joining the AMA in 1945, he served many years as executive secretary of the Indiana State Medical Association. He has been a medical executive for 32 years. Prior to that time he had a colorful career on three Indianapolis newspapers and as a radio sports broadcaster. It was then that he played tournament tennis with Bill Tilden, rode the Indianapolis Motor Speedway with Champion Ralph DePalma, and covered the great Ohio flood in 1937 with Westbrook Pegler. In his boyhood he played with Cole Porter, and when he

graduated from Princeton in 1915 he was proud of a classmate, Jim Forrestal, first Secretary of Defense. He knew Booth Tarkington and Bill Herschall, who inherited Riley's mantle as the "Hoosier Poet." He also knew intimately Cartoonist Gaar Williams, and Kin Hubbard, creator of "Abe Martin." His meetings with Meredith Nicholson, George Ade and Senator Albert Beveridge, the Lincoln biographer, were frequent.

And, among other things, Tom served 10 years in the Indiana legislature—one term in the House and two in the Senate.

He is taking over his new duties immediately.

Dr. Bauer to Head President's Committee

Louis H. Bauer, Secretary-General of the World Medical Association, has been selected by President Eisenhower to be chairman of the Committee on Medicine and the Health Professions to aid in implementing his "People to People Program."

FROM OUR EXCHANGES (Cont. from p. 59)

Some reasons for the high mortality in pediatric anesthesia are cited by Smith (*N. Y. State Jour. Med.*, 56:14, pp. 2212-2216). The author confesses that many causes exist for the high mortality rate in pediatric anesthesia. The chief ones he briefly lists as follows: (1) Administration of anesthesia to children when basic equipment is not available. (2) Administration of anesthesia to children who are toxic and dehydrated. (3) Inadequate observation of signs of anesthesia and condition of patient. (4) Errors in fluid therapy. (5) Failure to prevent aspiration of food.

* * * *

It is a relief in these times to discover a discussion of the causes of lung cancer that does not hinge on tobacco smoke. Hueper, in a long article with many tables, considers "The Environmental Causes of Cancer of the Lung Other than Tobacco Smoke." (*Dis. Chest*, XXX:2, pp. 141-159.)

* * * *

"If tuberculosis eradication is desired, each community, county, and state should locate the existing tubercle bacilli which are in the bodies of people and animals who react to tuberculin and act accordingly."

(Concluded on page 71)



Today's Health, popular educational magazine published by the American Medical Association, is now used in the reception rooms of more than 105,000 physicians.

The Woman's Auxiliary to the Connecticut State Medical Society sponsors subscriptions to this lending health magazine. It is available to physicians at half price and may be obtained by mailing the coupon on this page.

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National Survey Completed on Medical Society Participation in Television Programs

Medical societies in 545 television areas were recently asked "to what extent does your society participate in local television?" in a survey by the American Medical Association.

Within three weeks 190 of the questionnaires were returned, 171 from county medical societies and 19 from state societies. The tabulation indicated that 93 of the counties replying and 17 of the States replying now participate in local television programming.

Twenty-four county societies and six of the state societies are currently sponsoring television productions and 27 counties and six states now have programs in the planning stage. Forty-five counties and seven states reported that they have conducted television programs in prior years.

Thirty-two counties and seven states have joined with television stations to develop codes of cooperation; 39 counties in eight states furnish news releases to TV stations and 41 counties in eight states encourage their members to participate in local existing television programs.

A panel of physicians and a moderator was reported as the most popular type of local programs. Of the participating societies, 44 of them employed this format. Twenty-six other programs comprised a similar panel, but presented a physician as the moderator. Twelve of the programs featured a single commentator and eight programs comprised the use of film and dramatic skits.

Accident Control Programs Sponsored by Medical Associations

Working on the premise that a medical association is in a position to effectively center public attention on preventive health measures, medical societies in

three sections of the country have developed programs for that purpose.

The programs emphasize the proper care of emergency accident cases before the physician arrives and have warned against household accidents and poisoning hazards.

The medical society of Milwaukee county has distributed an 8½ x 11 inch flyer stating "Carelessness Kills!" The flyer stresses the danger of child poisoning and lists steps to be taken in such cases. It is designed to be included in the first aid file or attached to the cover of a telephone directory.

In New Orleans the Orleans Parish Medical Society participated in a week long accident prevention campaign proclaimed by the mayor of that city last October. The Society cooperated with the state pharmaceutical association and local health agencies to direct public attention toward home accident prevention and first aid treatment.

The California State Medical Association is engaged in promoting a program of home safety tips that originated in its Los Angeles County Society. An 11 x 15 inch first aid chart designed for use on the inside door of the medicine cabinet was issued in pamphlet form and was distributed by the association.

AMEF State Chairmen to Attend National Meeting, January 27

The 1957 campaign of the American Medical Education Foundation for the nation's medical schools will open officially with a meeting for state chairmen Sunday, January 27, at the Drake Hotel, Chicago.

The event will mark the beginning of the sixth annual drive to aid the medical schools and emphasis will be on the exchange of ideas and the development of campaign procedures. New information kits will be distributed to state chairmen as well as other materials which are to be made available to county chairmen and committeemen.

Medical Education Week Scheduled for Observance in April

Nationwide attention will be drawn to the achievements of medical schools in the United States during Medical Education Week, April 21-27.

This announcement followed a recent meeting of representatives from the sponsoring organizations, which comprise the Association of American Medical Colleges, the American Medical Association, the Student American Medical Association, the Woman's Auxiliary to the American Medical Association, the American Medical Education Foundation and the National Fund for Medical Education. Each of the sponsoring organizations is preparing a list of suggested activities for state and county medical societies, medical schools and allied groups. The materials are scheduled for distribution early this month.

AMA Develops Radio Series on Surgery

The progress of modern surgery will be the subject of a new series of radio transcriptions which the American Medical Association is preparing for use over local stations.

The transcriptions will provide an opportunity for listeners to hear on-the-spot descriptions of surgical procedures in abdominal, brain, chest and other surgery.

The series is being prepared by the Bureau of Health Education in consultation with officers in the AMA Section on Surgery. The 13-program series will be available for placement on radio stations by local medical societies about March 1.

THE DOCTOR'S OFFICE

Hugh S. P. Binnie, M.D. announces the opening of an office for the practice of general medicine and obstetrics at 232 Greenwood Avenue, Bethel.

Ronald W. Cooke, M.D. announces the opening of an office for the practice of general and pediatric surgery at 85 Jefferson Street, Hartford.

Francis A. Malyszka, M.D. announces the opening of an office for the general practice of medicine at 410 Noble Avenue, Bridgeport.

MEDICARE (Cont. from p. 46)

Claim forms have been distributed to the business offices of all general hospitals in the State and physicians may obtain them from that source. If anyone wishes to obtain a supply of forms in his office, they will be mailed to him upon request to the executive secretary's office. In filing a claim for services rendered under the Act the physician should complete the official claim form (D.A. 1863) in duplicate after reading the detailed instructions on the reverse of the form. Those instructions will clarify many points that otherwise might not be understood. The completed duplicate forms should be mailed to MEDICARE, P. O. Box 755, New Haven. It is suggested that the attending physician complete a third copy of the form to be retained in his own files.

It is realized that as at present provided this claim form is confusing and probably unnecessarily complicated and it is likely that in a short time a simpler form for physicians asking for information concerning medical service only will be authorized. However, for the present Form D.A. 1863 must be used and physicians are urged to see that their part of it is completed in all of its many details, otherwise the claim cannot be paid and delay will result in sending the form back and forth until it is properly filled out.

All claims will be reviewed and evaluated by a special MEDICARE Division of Connecticut Medical Service and after approval there, payment will be made by that agency directly to the physician rendering the service. In view of the full payment concept, the Government does not intend that the dependent pay more than the charges stipulated in the state fee schedule. Consequently, patients are being encouraged to ascertain that the physician whose services they seek is willing to provide services within the published schedule of allowances. If the attending physician believes that special circumstances of a given case warrant a payment in excess of that provided in the schedule of allowances, he must look to the government for the additional fee and not make a charge to the dependent.

This is a new program and is in some aspects without precedent. Because of the many necessary details of its administration, it may be difficult at first, but those who have worked on it with representatives of the Department of Defense are convinced that it is the intent to have its operation as simple as possible under the provisions of the law.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. E. Roland Hill, Mystic

President-Elect, Mrs. Paul W. Tisher, New Britain

First Vice-President, Mrs. Edwin R. Connors, Bridgeport

Second Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Corresponding Secretary, Mrs. Saul Karpel, New London

*Recording Secretary, Mrs. Norman H. Gardner,
East Hampton*

Treasurer, Mrs. J. Alfred Wilson, Meriden

President, Mrs. E. Roland Hill

Report on Presidents and Presidents-Elect Conference

The 13th Annual Conference of the Presidents, Presidents-Elect, and National Committee Chairmen of the Woman's Auxiliary to the American Medical Association was held at the Drake Hotel, Chicago, October 1 to 3, 1956. The theme of the Conference was "Health is our Greatest Heritage."

Following the usual opening order of business, Mrs. Robert Flanders, our president, gave her report in which she expanded on the theme of the Conference. She also urged all auxiliary members to "be community minded and friendly." Again this year we are cooperating with the American Heritage Foundation with the "Register and Vote" campaign. It is the duty of each one of us to vote and to be sure that every eligible member of our families and all our friends do the same.

Dr. Ernest B. Howard, assistant secretary, American Medical Association, addressed the conference on the "AMA Round-Up." He touched briefly on pertinent aspects of their program and urged careful study by auxiliary members of all medical legislation. Be informed yourself so that you can tell others of medicine's position.

The following conference panel discussions, with State presidents as components of each panel, were highlighted by technical experts speaking briefly in each field.

AMEF (American Medical Education Foundation) panel was moderated by Mrs. F. M. Fargher, chairman AMEF Committee, in which the story of the foundation and growth of AMEF was presented as the "House of AMEF." As the story of AMEF was developed the chairman built a clever house for us: foundation, walls, windows and doors and a roof. We learned that only one-fifth of the cost of medical education today is met by the schools and, therefore, four-fifths must be provided by outside

sources. The AMEF began in 1951 with \$500,000 to meet this challenge and has grown considerably since that time. Our own president, Mrs. E. Roland Hill, pointed out that the 82 medical schools today are the heart of the nation's health, spending \$12 to \$14,000 to educate each student and the AMEF is helping them meet this cost. An easy way for each of us to meet our share of the auxiliary quota of \$140,000 this year is to use the "In Memoriam" and "in appreciation" cards now available.

Mr. John Hedback, executive secretary, AMEF, outlined the future plans for AMEF with a special bouquet noted for the auxiliary, which has done more for it than any other one group. The auxiliary contributed \$106,000 last year.

Mrs. Paul Rauschenbach, chairman Civil Defense Committee, conducted a panel entitled "The Challenge" which defined civil defense as "self help and mutual aid." Members are urged to enroll in Red Cross first aid courses and learn to use the information. Civil defense handles community problems in disasters, such as sanitation and the like. Our role in civil defense is to inform the public through exhibits, visual aids, and to participate in local civil defense plans.

Mr. Frank Barton, secretary, Council on National Defense, AMA, reported that the FCDA has 200 completed hospital units to be used in testing programs. As a graphic demonstration of civil defense procedure each member of the Conference was given an evacuation slip at the end of this panel and sent to a specific station. My particular group was sent to the station which displayed the Navy's "Mr. Disaster."

The luncheon speaker on Monday was Dr. Horace Campbell of Denver, a member of the AMA committee on medical aspects of automotive injuries and deaths. Dr. Campbell's talk stressed that while we can not totally prevent accidents we can try to prevent injury through safety in cars, by the use of

seat belts, safety panels, etc. It is up to the women to see that our husbands buy safe cars.

The opening afternoon panel was Safety. The participants stressed these points: reduce public apathy; encourage driver education in the schools; observe traffic signals; encourage school health examinations and use safety posters in your city. Remember, there were 5,500 accidents last year to persons below the age of 14; stress home safety and promote the auxiliary baby-sitter training program called "Gems" (good emergency mother substitutes).

Following this, Mrs. Thomas F. Reid, chairman of the Safety Committee introduced her guest, Miss Alice Mills, director of the women's activities of the National Safety Council, who reiterated the points brought out by the panel participants reminding us that forethought, time and discipline will help prevent home accidents.

Recruitment was the topic of the next panel, led by Mrs. L. B. Jacobson, chairman of the Recruitment Committee. This Committee has been changed from Nurse Recruitment as we want to encourage young people to study any of the 150 allied health careers open to high school graduates. We can develop programs locally by having guest speakers, bulletins, demonstrations, etc., for the high school students giving the specific information as to educational requirements, costs, and years of training necessary to become proficient in the field of their choice.

Mrs. Muriel Henry, director of programs, Committee on Careers in Nursing, was a guest on this panel. She told of the development of future nurses clubs and added that scholarships are needed for graduate nurses.

The afternoon session concluded with a panel on Mental Health presented by Mrs. Aaron Margulis, chairman, Mental Health Committee. Many possible ways of participating in a mental health program were presented. Mental illness is a major problem of medical care today and this year we are particularly aiming our programs at the psychiatric problems of children.

Dr. Irene Josselyn of Chicago spoke on these psychiatric problems in children. She urged us to help prepare communities to recognize problems of emotionally disturbed children and to realize that they do need help. Most mothers realize that they are not M.D.'s to cure all illnesses, but what

about emotional illnesses? "Remember," said Dr. Josselyn, "in beginning any mental health program in a community you don't have to start at the top—an ideal set up—do the best you can for your community and know your limits."

Mrs. E. Arthur Underwood, first vice president and chairman of the Organization Committee, through her panel suggested ways to gain new members and keep them active. It was interesting to note the various methods used by the States to gain and keep members. These included bowling groups, a fashion show with State Board members as models, each member explaining her function on the Board as she modeled. Personal contacts must be made to keep an active membership. Remember it is an honor and a privilege to belong.

The Program Panel gave various suggestions for developing a strong auxiliary through programs adapted to local health needs. Mrs. John M. Chennault, chairman of the Program Committee then introduced her guests, Dr. Ralph DeForest, secretary, AMA Council on Medical Physics and Committee on Rehabilitation, who told of the auxiliary's opportunities in rehabilitation programs. He pointed out that no agency rehabilitates—that people do it—the auxiliary can best help by finding out what local communities need to rehabilitate people, and then set up a program.

Mr. Thomas Hendricks, secretary, AMA Council on Medical Service, pointed up the need for a flexible continuing program. He also said that public service must be added to any auxiliary program.

Mrs. F. Erwin Tracy, chairman of Public Relations Committee, conducted a most stimulating panel on Public Relations. Her panel members gave specific examples of local public relations projects carried out in cooperation with their medical societies. Rhode Island, for example, uses a 15 minute TV series. Mr. Leo Brown, director, AMA Department of Public Relations, spoke on "Medical Education Week and Science Fairs. "True Happiness comes from Helping Others" said Mr. Brown.

The Science Fairs are sponsored by the science clubs of America but the Woman's Auxiliary can join with other groups to finance and sponsor these fairs. Medical Education Week will be April 21 to 27. There will be no fund raising, but the function of the auxiliary will be to inform persons of the progress of medicine and the problems the medical schools are facing today.

The Legislation Panel was conducted by Mrs. Charles L. Goodhand, chairman of the Legislation Committee. Reinsurance, Government Guaranteed Loans for Medical Facilities, the Bricker Amendment, Jenkins-Keogh Legislation and Cash Disability Benefits (HR7225) were among the topics discussed. Mr. C. Joseph Stetler, director, AMA Law Department, spoke on the role of the auxiliary in medical legislation and informed us how to form a State program. Learn the bills—spread the word—contact your Congressmen.

Dr. David B. Allman, president-elect of the American Medical Association, was our luncheon speaker on October 2. His talk, "Bees in the Auxiliary Bonnet for 1957," was inspiring and informative. First, barnstorm, carry the conference back home; broadcast—tell the medicine story; button-hole—correct misunderstandings and misconceptions of medicine; blaze new trails, to give service to the American people. Dr. Allman concluded that because of the AMA and its Auxiliary the health of the American people far surpasses that of any nation in the world.

Today's Health, Mrs. C. Rodney Stoltz, chairman of *Today's Health* Committee, announced that the goal for this year is 75,000 subscriptions. Mr. W. W. Hetherington, managing publisher of *Today's Health* was the guest. He pointed out that 5,520 persons a year or 115 a week, or 16 daily, see the magazine in the office of the physician who subscribes to *Today's Health*. Reception Room Readership, the 3 R's of *Today's Health* are effective. Let us work to place it in doctors' offices, beauty salons, schools and homes. This is the only authentic health magazine, published for the laity, containing truthful medical facts.

After the panels were concluded a short symposium was held on other aspects of auxiliary work. Mrs. E. M. Egan, chairman of the Publications Committee, spoke on the new design of the bulletin cover, but reminded us that what is between the covers is most important. Subscribe to the *Bulletin* to be informed on auxiliary work. The circulation committee chairman, Mrs. Mathew M. Hosmer, announced that prizes would be given to the State and the county having the largest number of *Bulletin* subscriptions.

Mrs. George Turner, chairman of the History Committee, reminded us that after we do our job it is most important to have it recorded for future

reference. During the conference several speakers had referred to an inscription over a doorway in Washington which read "What is past is prologue." Mrs. Turner added that the other door contained the words "Study the Past" which we do through accurate historical records.

The speakers on Finance, Parliamentary Procedure, Reference and Revisions added a light touch to the meeting by giving their suggestions in song.

The President and President-Elect, Mrs. Flanders and Mrs. Craig, entertained the conference members at a reception on Monday evening, and on Tuesday we were guests at a no-host dinner and puppet opera at the Kungsholm Restaurant.

The final day of the meeting was devoted to a tour of the AMA headquarters building and to a viewing of films. These films, "The Case of the Doubting Doctor" and the "Invisible Committee," were enlightening and I recommend them to you for local use.

It was a pleasure and a privilege for me to represent you at this Conference—it was a stimulating and profitable experience.

Respectfully submitted,

(Mrs. Paul) Dorothy F. Tisher

From Indemnity to Service Plan

Buffalo Blue Shield became a service program starting November 1, when it began offering service contracts for the first time. The change from indemnity to service was the decision of Buffalo's participating physicians, who voted to accept the proposed change. Their vote was described as "overwhelmingly" in favor of the service program.

Commenting on the Buffalo Plan's move, the *Buffalo Evening News* editorialized: ". . . it is heartening indeed to find most of the physician participants in the Blue Shield medical prepayment plan ready to broaden Blue Shield coverage by offering a full-payment, service-type contract to families of moderate means." The editorial stated that the vote in favor of the service program was "in the public interest and they (the doctors) are to be commended for it."

With the Buffalo Plan's conversion to a service program, service-type contracts are offered by 50 United States Blue Shield Plans with 75 per cent of the United States membership.

OBITUARIES

William F. Collins, M.D.
1882 - 1956



Dr. William F. Collins, 74, of 181 Howard Avenue, a founder and past president of St. Raphael's Hospital who had practiced medicine in New Haven for 50 years, died at his home November 5 from coronary disease.

Dr. Collins graduated from Yale Medical School in 1904, and served his internship in St. Mark's Hospital in New York City. He began the general practice of medicine in New Haven in 1906, and continued in practice up to a short time before his death.

A native of New Haven, he was the son of the late Thomas and Bridget Welch Collins. He leaves his widow, Jane Shanley Collins; three daughters, Mrs. John Gilboy of Waverly, Pennsylvania, Mrs. Warren Stannard of Indianapolis, Indiana, and Miss Ann Collins of New Haven; a son, Dr. William F. Collins, Jr., of Cleveland, Ohio; and a brother, Thomas J. Collins, also of New Haven.

Dr. Collins remained to the end a true and faithful family doctor. Throughout this past half century he was ever the devoted advisor and counsellor to his patients, and they were equally loyal to him.

Always a student and scholar, he could converse almost as well in Latin as in his native tongue, and the study of great literature was an avocation. It was an inspiration to converse with him in many subjects other than medicine, and one always left his company with a fervent desire to follow his example. None ever heard him speak a sharp or unkind word, as his heart was filled with that charity so clearly defined in the 13th Chapter of the First Epistle of St. Paul to the Corinthians.

Those of us who have known him all these decades will miss him. Bill Collins was a gentle soul.

Charles T. Flynn, M.D.

Malcolm S. Eveleth, M.D.
1913 - 1956



Malcolm Eveleth died of acute coronary occlusion on November 8, 1956, at the untimely age of 43 years. His death came suddenly in the evening, at home, following an active day spent in the care of his patients. Mac had a precious gift for making friends, and his departure in the prime of life, at the height of a successful career in orthopedic surgery, leaves all of us with a deep sense of personal loss.

Dr. Eveleth was born February 5, 1913 in Washington, D. C., his family moving to Detroit, Michigan when he was twelve. After receiving his early education in Detroit, Mac graduated from the University of Michigan in 1934 and the Johns Hopkins Medical School in 1938. His years of internship and residency were spent at the University Hospitals, Cleveland, Ohio. In 1941 Mac came to the New Haven Hospital as an associate resident in orthopedic surgery, and was promoted to the residency in 1942. He subsequently assumed charge of the orthopedic service at the hospital and in 1946 was elevated to the rank of assistant professor of orthopedic surgery at Yale University Medical School. Several scientific papers were published at this time, including evaluations of the use of prostigmine in poliomyelitis and of the sulfanilamides in compound fractures. Entering private practice in June, 1949, Mac quickly succeeded in building up a large following of patients. At the time of his death he was Associate Clinical Professor of Orthopedic Surgery at Yale, Attending Orthopedic Surgeon at the Grace-New Haven Community Hospital, Diplomate of the American Board of Orthopedic Surgery, and a member of numerous professional and social organizations, including the American Medical Association, American Association of Orthopedic Surgeons, Connecticut State Medical Society, New Haven County Medical Association, Graduates Club (New Haven) and the Branford Yacht Club. He is survived by his wife, the former Bernice Chapin, by his parents, and two children, Edward and Jane.

To Mac Eveleth patients were always people, not cases, individuals who needed—and received—unrationed shares of his time and thought. In consequence Mac's approach never betrayed any hurry, still less any glaze of self protective ostentation. To those who might take him for unassuming—which, in his deepest nature, he was—it came as a surprise to learn how independent were his opinions, how shrewd his valuations of men and their devious motives. Amused, perhaps a little saddened, by the human comedy, his great tolerance of people and unfailing humor kept him warm, considerate, friendly, witty. He was comforting to talk to, because to talk to Mac was to touch a man. We shall miss him very much.

Russell V. Fuldner, M.D.

Carl C. Giannotti, M.D.

1892 - 1956

Dr. Carl C. Giannotti died on November 7, 1956 in St. Raphael's Hospital, New Haven after an illness of six weeks.

Born in New Haven, Dr. Giannotti graduated from Hillhouse High School, Georgetown University and Albany Medical College. He interned at the Hospital of St. Raphael and began his practice of medicine in 1920, coming to West Haven in 1926.

Dr. Giannotti had been team doctor for all West Haven School athletic teams since 1928 and school physician since 1936. He was taken ill while attending a West Haven game at the Municipal Stadium.

He was a member of the Connecticut State and New Haven County Medical Associations as well as the American Medical Association.

Surviving are two sons, Carl C. Jr. and Joseph F. Giannotti.

Dr. Giannotti has been praised for his long association with the West Haven school system. He was a valuable man, especially to the many athletes whom he aided throughout his long service with the schools.

P. A. Piccolo, M.D.

FROM OUR EXCHANGES (*Cont. from p. 63*)

The author stresses the fact that well defined exogenous physical and chemical agents are involved in the production of occupational cancer of the respiratory system in members of restricted worker groups. Studies indicate that special occupations have remarkable differences in their lung cancer rate. It is recognized that there are environmental carcinogens (respiratory) in the atmosphere, especially in urban areas. There is a higher lung cancer death for urban populations over rural populations. It is noted that, while occupational and industry-related carcinogens in air pollution seem to play an important role in the causation of lung cancer and its recent increase, it is obvious that they are not the only factors involved. Research on lung cancer should be conducted on a broad base, including not only inhalents but also agents entering the body through nonrespiratory routes.

AROUND THE STATE

A Statistical View of State Mental Patients

One of the most cogent facts the Department of Mental Health must consider in its planning is the steady ascent each year in the number of admissions to our state hospitals. During the fiscal year 1955, admissions to Connecticut, Norwich and Fairfield State Hospitals were an unprecedented 3,860. In the last fiscal year, ending June 30, 1956, they climbed 9.5 per cent—to 4,227, taxing to the utmost the staffs and resources of the hospitals. Since 1931 admissions have risen by more than 175 per cent. In the past decade alone the increase was more than 65 per cent.

But in the last few years the number of patients on the books (occupying beds or on extended visit) in relation to the state's civilian population has been declining following a steady rise of at least five decades.

In addition to the 10,309 state hospital patients on the books on June 30, 1956, an estimated 825 Connecticut residents were mental patients in various VA hospitals. Still other residents, on which information was not available, were patients at private mental institutions in and out of the State. These figures indicate that at least 1 of every 200 Connecticut residents is under treatment in a mental hospital—over 90 per cent of whom are treated in the State's mental hospitals.

The admission rate per 100,000 civilian population to our State hospitals doubled in a twenty-five year period. In 1930 it was 86.2, and in 1955, 172.8. In the latter year the admission rate per 100,000 civilian population for the United States as a whole was 109.2.

Of special concern in our planning is the sharp rise in the admissions of patients aged 65 and over. In the period from 1950 to 1955 there was an increase of 48.2 per cent in the admissions from this group.

Connecticut Regional Blood Program

From time to time the Blood Center is questioned by physicians concerning the standards which are set in this program for the medical selection of donors. The Center is aware of the impossibility of having all members of the medical profession or

indeed any large group think alike. It, however, disclaims any suggestion that these standards are arbitrary.

This program is operated under Federal License 190; a Federal License being required in order to enable the Center to transport blood or blood products across State boundaries. The Federal License is issued by the National Institutes of Health of the Department of Health, Education, and Welfare. This group is responsible, by act of Congress, for the control of all biological products in interstate commerce.

The Center is annually inspected by physicians from the National Institute of Health in order to insure that the standards laid down in the License are being maintained at 45 Retreat Avenue, Hartford. This is a safeguard for the health of our citizens, in addition to the license from the State Department of Health.

	JULY 1, 1956 THROUGH	
	NOVEMBER 1956	NOVEMBER 30, 1956
DONORS		
Donors accepted	7,703	36,548
Donors rejected	823	3,950
Donors registered	8,526	40,498
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from center	6,832	30,548
Blood collected by hospitals.....	569	3,538
To fractionation stock pile.....	135	135
To out of state hospitals.....	146	466
	7,682	34,687
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	111	500
Processed into packed cells.....	4	25
Processed into liquid plasma.....	1,183	4,365
	1,298	4,890
Discarded — unfit and broken.....	43	248
Grand Total — distribution of blood..	9,023	39,825
Blood returned to center for processing into plasma and fractions.....	1,087	3,557
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	39	157
Fresh frozen plasma (125 cc.).....	230	1,000
Serum albumin (100 cc.).....	137	1,026
Packed red cells (bottles).....	4	25
Fibrinogen (bottles)	8	8

A Message to Physicians

Just prior to the opening of the Commission on Alcoholism's Blue Hills Hospital in Hartford in April 1950, a message was sent to all physicians in Connecticut announcing the opening, stating the procedure to be followed by physicians in referring patients to the hospital and suggesting criteria for selection of patients for referral.

It is considered appropriate at this time to restate the admission policy at the Blue Hills Hospital as a review for all physicians in Connecticut and particularly to bring the policy to the attention of new and younger physicians who have recently established practice in Connecticut.

The Blue Hills Hospital is a specialized, state-supported institution for the inpatient care and treatment of alcoholics who are residents of Connecticut and who are in need of such care. Of its 50 beds, 42 are allocated to male and 8 to female patients. As a small, specialized facility, the Blue Hills Hospital is not able to furnish all of the services normally expected of a general hospital. Its staff is minimum in size. Its equipment and services do not include radiology, orthopedics, isolated accommodations for contagious diseases, or maximum security and protection for seriously disturbed, mentally ill patients. Nor can alcoholics be accepted who have several physical illnesses and in need of the intensive medical and nursing attention which Blue Hills is not equipped to supply. Because of its staff limitations, too, the hospital can accept patients for admissions only during certain limited hours in the working days of each week.

In spite of the limitations on its ability to render services to alcoholics and their families, physicians and interested agencies, the Commission on Alcoholism admits at its Blue Hills Hospital an average of more than twenty cases each week and more than eleven hundred cases each year. Over forty per cent of these admissions are accepted from referrals by private physicians.

Admissions to Blue Hills are accepted from only two sources of referral—from any private physician licensed to practice medicine in Connecticut, and from the Commission's five out-patient clinics. Referrals from either of these sources means that the patient under consideration for referral has been evaluated by a physician in accordance with the following criteria for determining his (or her)

eligibility for and admissibility to care at Blue Hills:

- (1) The patient must be a resident of Connecticut.
- (2) The patient must be free from contagious disease and from a physical or mental illness which requires a type of treatment Blue Hills cannot supply;
- (3) The patient must present, in the opinion of the referring agency, a reasonable ability to use a period of hospitalization constructively.

The Commission discourages the referral of patients who have a long history of repeated admissions to hospital; patients who exploit the hospital as a place to simply sober up preparatory to the next drinking bout; and patients who demonstrate no motivation toward real treatment of their emotional and drinking problems either while at the hospital or after discharge from it. The limited number of beds available are most effectively used when they are allotted to patients who sincerely want help with their drinking problem and who make a sincere effort to follow a planned course of treatment while at the hospital and after discharge from it.

In accordance with the above criteria, patients are admitted to Blue Hills between the hours of 8:30 A. M. and 4:00 P. M., Monday through Friday, and from 8:30 A. M. to 12:00 noon on Saturdays. No referrals for admissions outside of these hours or on Sundays or holidays can be accepted.

Charges at the hospital are \$11 per day and \$77 per week. Although, in cases of hardship, charges will be scaled downward, the Commission believes that it is good therapy for every patient to make a personal investment in his own recovery. It therefore expects every patient to pay for his care to the extent compatible with his financial resources as determined through conference with the patient by the hospital's staff.

The Commission on Alcoholism is anxious to be of the greatest possible service to physicians in Connecticut. We can serve you and your clients best if you will appreciate and be tolerant of our limitations and refer patients to us with the closest possible adherence to the selection criteria as stated above.

Cancer Society

Edward J. Ottenheimer of Willimantic was re-elected president of the Connecticut Division, American Cancer Society, at its annual meeting in

October, 1956. At the same meeting Donald A. Bristoll of New Britain was elected first vice president and John M. Morris of New Haven, secretary. The 1956 campaign drive raised \$637,445, a record breaker for Connecticut.

Recognizing the life-saving promise, in tracking down certain forms of cancer in women earlier through Papanicolaou tests, your State Cancer Society has activated or helped in the development of three additional centers which offer this vital detection opportunity to women in the State. State grant funds make possible the training of technicians capable of interpreting "Pap" smear slides in the New Britain, Norwalk and Waterbury Districts, to serve the surrounding regional areas. Programs already offered are in New Haven, Hartford and Bridgeport.

Fairfield County

Frank Turchik will be formally installed as president of the Bridgeport Medical Association on January 15 at the Fairfield Inn, succeeding Edwin R. Connors. Other officers of the society are: President-Elect, Daniel B. Hardenbergh; Vice President, Peter Pileggi; Treasurer, John Paget; Secretary, John C. Olsavsky.

Postgraduate lectures in clinical neurology under the auspices of the Greater Bridgeport Chapter of the American Academy of General Practice commence this month at Bridgeport Hospital. Gilbert Glaser, associate professor of neurology at Yale University School of Medicine is the lecturer. The course will continue through February.

Recently elected president of the Norwalk Medical Society was Laszlo Steinberger, following Francis J. Kalaman in that office.

New to the office of president of the Danbury Medical Society is William Sinton, who succeeds Albert J. Trimpert.

Hartford County

William J. Lahey, director of medical education at St. Francis Hospital, Hartford was elected president of the Connecticut Trudeau Society at its annual meeting in November, 1956. Other new officers include Vice President, Max G. Carter, thoracic surgeon, St. Raphael's Hospital, New Haven; Secretary-Treasurer, R. C. Edson, medical director, Cedarcrest Hospital, Newington. Elected to the executive committee were: P. Mason de la

Vergne, superintendent, Undercliff Hospital, Meriden; Winfield Kelley, chief surgeon, Uncas-on-Thames Sanatorium, Norwich, and Nicholas D. D'Esopo, chief of the pulmonary disease services, West Haven Veterans Administration Hospital.

Dewey Katz of Hartford addressed the New England Ophthalmological Society in Boston recently on the subject, "The Intrasccleral Nerve Loop, Its Anatomical Characteristics and Its Clinical Significance."

George A. Gosselin of West Hartford died suddenly at his home on November 25, 1956. Dr. Gosselin practised neurology in Waterbury and Hartford for 34 years.

J. Howard Johnston of Hartford is one of the co-authors of an article entitled "Usefulness of Bioflavonoids and Ascorbic Acid in Treatment of Common Cold" published in the *Journal AMA*, November 24, 1956.

Nicholas A. Giorgio was elected president of the medical and surgical staff at St. Francis Hospital, Hartford at the annual meeting of the Board of Directors in December. Other officers elected were Lewis P. James, president-elect; James Missett, secretary; Edward White, assistant secretary; Timothy L. Curran, treasurer; Thomas M. Feeney, chairman of the executive committee.

Litchfield County

Thomas J. Danaher of Torrington, in addition to all his other responsibilities, has been elected president of the Torrington Y. M. C. A. Board of Directors.

Middlesex County

William C. Kennedy of Middletown died at the Middlesex Hospital in November after a long illness. Dr. Kennedy practised medicine in Torrington for many years and moved to Middletown in 1951. He was 74 years old at the time of his death.

A. Benjamin Rofkind of Middletown has been appointed clinical director of medical and surgical services at Connecticut State Hospital in Middletown.

Norman Gardner attended the Clinical Congress of the AMA in Seattle, Washington at the end of November.

William Y. Chen resigned as the Health Officer in Middletown. Mario Palmieri is acting health officer.

DIAGNOSTIC AID

Reduced Hypermotility with Pro-Banthine® Improves Visualization



*Posterior-anterior film: definite hyperperistalsis with poor duodenal visualization.**



Posterior-anterior film after 15 mg. of Pro-Banthine intramuscularly: chronic duodenal ulceration clearly disclosed.

The same anticholinergic action which has made Pro-Banthine (brand of propantheline bromide) the outstanding therapeutic agent in peptic ulcer has also proved valuable in diagnosis.

By controlling the hypermotility, Pro-Banthine may permit delineation of a lesion otherwise not clearly visualized.

The technic is simple: If the first set of films shows hypermotility but no filling defect is demonstrable, reexamination is

done a few minutes after intramuscular injection of 15 mg. or a half hour after oral administration of 30 mg. of Pro-Banthine.

This procedure has the additional advantage of demonstrating the patient's response to a given dosage of the drug.

G. D. Searle & Co., Chicago 80, Illinois,
Research in the Service of Medicine.

*Roentgenograms courtesy of I. Richard Schwartz, M.D., Kings County Gastrointestinal Clinic, Brooklyn, N.Y.

SEARLE

Malcolm R. Blakeslee died suddenly at the age of 56 on Saturday, December 1. He was an associate psychiatrist at Elmerest Manor in Portland.

Middlesex County Cardiovascular Research Project

A unique cardiovascular research project will soon begin in Middlesex County, Connecticut to help solve the enigma of morbidity and epidemiology of coronary artery disease and cerebrovascular accidents. At the present time there is no answer anywhere to the morbidity problem and our knowledge of epidemiology is grossly incomplete and of questionable preventive value.

The site for the selection was made on the basis of the fact that Connecticut has one of the highest mortality rates for these diseases in the nation, and because Middlesex County is a representative cross-section of the State's rural-urban population.

In outline form the project shall be conducted in the following manner:

1. The diseases reported are any form of coronary artery disease and cerebral vascular accidents.
2. Reports are made only on residents of Middlesex County.
3. Physicians report cases as they diagnose or treat them.
4. After case reporting is well under way, nutritional and sociological investigations will begin on a sampling basis.
5. The pilot study is intended to run for one year at which time statistical analyses shall be prepared.
6. Clinical-pathological correlation is planned on the basis of autopsies performed in participating hospitals.

All physicians in Middlesex County and in some fringe areas are being supplied with special reporting forms and additional information. The ones contacted in the fringe areas were the ones we felt would be most likely to treat some patients from the county under study, but we realize that we may have overlooked some who will have cases to report. Any physician who has such a case to report and lacks the forms can get them along with any additional information from: Connecticut Cardiovascular Disease Study Committee, 436 Capitol Avenue, Hartford 15, Connecticut.

The study committee has the joint sponsorship of the American Heart Association, Connecticut Heart

Association, Middlesex Chapter of the Connecticut Heart Association, Middlesex County Medical Association, Connecticut State Department of Health, and the U. S. Public Health Service.

Only complete and sustained reporting will give the answers to these timely and crucial medical problems.

New Haven County

Not long after his arrival in Columbia, South America, Ashley W. Oughterson formerly of New Haven, was killed in a plane crash on November 18, 1956. Dr. Oughterson was in the process of heading the development of improved medical schools in Columbia under a Rockefeller Foundation grant.

Dr. Allan J. Ryan, Meriden, Played Major Part in One Year Project to Publish First Sports Edition of Journal AMA

Dr. Allan J. Ryan, of Meriden, recently made a major contribution to medicine in sports when he completed a year of writing and research to produce a special edition of the *Journal of the American Medical Association* for release during the 1956 Olympic games in Australia.

A member of the AMA Committee on Sports Injuries, Dr. Ryan was requested to accept editorial supervision of the sports edition by Dr. Austin Smith, editor of the *Journal*, early in 1955. The project was completed in time for release in the November 17, 1956 issue. The content comprised ten original articles and three editorials on the medical aspects of games and sports which have won the acclaim of physicians, coaches, athletic directors and others concerned with the continuing expansion of all sports activities.

Three of the special articles and a guest editorial were written by Dr. Ryan. Remarking that physicians throughout history have displayed interest in the physiological effects of exercise, Dr. Ryan emphasized in his editorial the increasing importance of sports in American life.

"Within the past year," he stated, "President Eisenhower has called two meetings of sports leaders at the White House. The result has been a decision to appoint a presidential Council on Youth Fitness at the Cabinet level and to create a Citizen's Advisory Committee to this council.

"The appearance of two such organizations as

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the American College of Sports Medicine, and the Western Council of Sports Medicine within the past few years gives further indication that we are on the threshold of an even greater interest in the scientific study and development of sport in the United States."

The articles by Dr. Ryan were entitled "The Olympic Games and the Olympic Ideal," "A Medical History of Gymnastics" and "The Physician as a Sportsman."

Other articles which Dr. Ryan obtained for publication in the special edition included "Physical Fitness For All," by R. J. H. Kiphuth, well known Yale University swimming coach; "Nutrition and Athletic Performance" by Drs. Theodore B. Van Itallie, Leonardo Sinisterra and Frederick J. Stare, Department of Public Health, Harvard School of Public Health; "Prevention of Injury in Athletics," by Dr. Augustus Thorndike, chief surgeon of Harvard University's Athletic Department; "Relationship of Physical Fitness to Athletic Performance and Sports," by Dr. T. K. Cureton, Urbana, Illinois; "The International Federation for Sports Medicine," by Dr. Guiseppe La Cava, Rome, Italy; "Effect of Warming-Up Upon Physical Performance," by P. V. Karpovich, M.D. and C. J. Hale, Ph.D., Springfield, Massachusetts; and "Study of the Longevity and Morbidity of College Athletes," by Drs. W. J. Martin, F. R. Heilman, D. R. Nichols, W. E. Wellman, and J. E. Geraci, Rochester, Minnesota.

Dr. Thorndike, who is chairman of the AMA Committee on Sports Injuries, recommended that an injury prevention program be developed by sports organizations. He also spoke for the development of a method of recording injuries on a national scale, preferably through the National Collegiate Athletic Association.

Dr. Thorndike states his belief that the incidence of sports injuries is too high, but points out that only a few scattered figures are available in this connection. The record of deaths, however, shows that during the 1955 football season there were ten recorded deaths during play and that during the 32 years preceding 1951, the New York City Medical Examiner's office recorded 43 deaths in baseball, 22 in football, 21 in boxing and seven in basketball. One major life insurance company reported three fatalities in golf in a two year period.

Dr. Thorndike's recommended program would also include compulsory preseason physical examinations for all competitors, followed by measures

to prevent repeating old injuries. He said that team physicians must be given a free hand—without pressure from coaches or trainers—to decide when a player should be kept out of a game to prevent aggravating an injury. The team physician also should be allowed to serve as "observer," picking out the player who limps or some other warning of potential serious injury. The physician is definitely the person to do this, the author declared, since coaches or trainers are too busy with technicalities of play to add this to their responsibilities. However, coaches and trainers must do their part by teaching players how to prevent undue exposure of vulnerable parts of the body and to guard against the difficult problems of over-training.

Dr. Thorndike pointed out that industry and insurance companies have made an organized effort to reduce industrial accidents, but little has been done by coaches, trainers and others in the field of sports to develop a safety training program for athletes.

"Whatever program is adopted to reduce sports injuries will require deep thought and cooperation from all sides of the field; the professional, the amateur, the schools and those responsible for sports in public and private playgrounds," he said.

New London County

Alice Hamilton, a pioneer in industrial medicine in the United States, has been named "Medical Woman of the Year" by the Boston Chapter of the American Medical Women's Association.

Windham County

Sidney Vernon of Willimantic is the author of "The Importance of Ground Substance in Surgical Concepts" published in *The American Journal of Surgery*, September, 1956. In that same issue appeared an editorial by Dr. Vernon entitled, "The Unit of Freedom."

Yale University School of Medicine

Ira V. Hiscock, professor of public health at Yale University School of Medicine, has been elected an Honorary Fellow of the Royal Society of Health (England). The scroll was presented to Dr. Hiscock by Dr. Albert Parker, the deputy chairman of the Council of the Royal Society, at a dinner meeting of the Governing Council of the American Public Health Association at this group's annual meeting in November.



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SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL

Middletown, Connecticut

Schedule of Noon Conferences for the month of January

Wednesday, January 2, 10:00 A. M.

Tumor conference

Friday, January 4, noon

Grand rounds

Monday, January 7, noon

Clinical-pathologic conference

Friday, January 11, noon

Grand rounds

Monday, January 14, noon

James Hennessy, M.D.

Problems in the diagnosis of pulmonary disease

Friday, January 18, noon

Grand rounds

Monday, January 21, noon

Marvin B. Harvard, Jr., M.D.

Present concepts in the treatment of prostatic cancer

Friday, January 25, noon

Grand rounds

Monday, January 28, noon

Seymour R. Lipsky, M.D.

Diet and atherosclerosis

Wednesday, January 30, noon

Gilbert Glaser, M.D.

Diseases of muscle

HARTFORD HOSPITAL

Saturday Morning, 11 o'clock Guest Speakers December 29, 1956 to March 30, 1957

January 5

Raymond E. Weston, M.D., PH.D., head of the cardiovascular and metabolic research service, Montefiore Hospital, New York City

Current concepts of diuretic therapy

January 12

Arthur L. Haskins, M.D., assistant professor of obstetrics and gynecology, Washington University School of Medicine, St. Louis, Missouri

10:00 A. M. The medical treatment of endometriosis

11:00 A. M. The therapeutics of endocrines in gynecology

January 19

Nicholas D. D'Esopo, M.D., chief, Tbc. Division, West Haven Veterans Hospital, West Haven, Connecticut

Newer aspects of the treatment of tuberculosis

January 26

Richard H. Overholt, M.D., chief, Overholt Thoracic Clinic, Boston, Massachusetts

Carcinoma of the lung—shadow vs. substance

February 2

William Kaufman, M.D., F.A.C.P., Bridgeport, Connecticut

Some psychosomatic aspects of allergy

February 9

Langdon Parson, M.D., professor of gynecology, Boston University School of Medicine

10:00 A. M. Problems of the teen-age girl

11:00 A. M. Dysmenorrhea

February 16

Mark Hayes, M.D., associate professor of surgery, Yale University School of Medicine

Water and electrolytes in surgery

February 23

C. Lee Buxton, M.D., professor of obstetrics and gynecology, Yale University School of Medicine

10:00 A. M. Factors influencing fertility potential

11:00 A. M. Electronic identification of foetal distress

March 2

H. M. Marvin, M.D., associate clinical professor of medicine, Yale University School of Medicine

Unusual manifestations and unusual types of heart disease

March 9

Benjamin Spector, M.D., professor of bioanatomy, Tufts University School of Medicine

Some aspects of the autonomic nervous system in health and disease

March 16

Philip LeCompte, M.D., pathologist, Faulkner Hospital, Boston, Massachusetts

Pancreas in diabetes mellitus

March 23

Col. Joseph R. Shaeffer, chief, Department of Atomic Casualties Studies, Walter Reed Army Hospital, Instructor of research, Walter Reed Army Medical Center, Washington, D. C. and

10:00 A. M. - 12:00 NOON

Col. Albert J. Glass, chief psychiatric and neurologic

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consultant, Office of the Surgeon General, Washington, D. C.

The medical and hospital problems in the care of mass casualties

March 30

Theodore Klumpp, M.D., president, Winthrop-Stearns Chemical Company, New York City

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AMEF STATE CHAIRMEN TO MEET JANUARY 27

The 1957 fund drive of the American Medical Education Foundation for the nation's medical schools will officially open with a meeting for State chairmen on Sunday, January 27, at the Drake Hotel, Chicago. Emphasis at this sixth annual meeting will be on the exchange of ideas and the formation of suggested developments for the AMEF. New work kits will be distributed to State chairmen along with other materials which will be available to county chairmen and committeemen. Each State may send one delegate although any physicians interested in this effort are more than welcome to attend.

POSTGRADUATE COURSE IN DIABETES AND BASIC METABOLIC PROBLEMS

January 30, 31 and February 1, 1957, at Columbus

The American Diabetes Association will hold its Fifth Postgraduate Course in Diabetes and Basic Metabolic Problems at The Ohio State University Health Center, Columbus, Ohio, January 30, 31, and February 1, 1957.

For further information and registration forms, write to: American Diabetes Association, 1 East 45th Street, New York 17, N. Y.

AMA CONGRESS STRESSES HEALTH ON THE JOB

Safeguarding the worker's health will be the chief consideration of representatives of labor, management, government and the medical profession at the 17th annual Congress on Industrial Health to be held February 4-6 at the Biltmore Hotel, Los Angeles. Sponsored by the AMA's Council on Industrial Health, the Congress is open to all physicians, nurses, industrial hygienists, engineers and others interested in occupational health.

A special session on "Vision in Industry" will be presented Monday afternoon, February 4, and Tuesday morning, February 5, in cooperation with the National Society for the Prevention of Blindness. This presentation will cover such things as the components of a vision program, evaluation of vision screening methods, testing for color perception, estimation of loss of visual efficiency, relationships between illumination and vision, the successful eye protection program, prescription safety goggles, emergency treatment of eye chemical injuries, screening for eye disease, and respon-

sibilities and limitations of the industrial nurse in a vision program.

Other topics include: "Health Hazards of Agricultural Chemicals," "New Concepts in the Management of Burns," and "New Developments in Hearing Loss Due to Industrial Noise." A number of scientific exhibits directly related to these problems will be displayed. In addition, special tours of the research laboratories of the Sub-committee on Noise in Industry have been scheduled for Monday morning and evening and Thursday morning. Advance reservations should be made for these tours since space is limited. Further information may be secured from the Council.

CONGRESS ON MEDICAL EDUCATION, FEBRUARY 10-12

The 53rd annual Congress on Medical Education and Licensure will be held in Chicago's Palmer House, February 10-12. As in other years, the February program will center around an important current problem: graduate medical education for general practice. Because of the general concern over preparation for general practice, the AMA Council on Medical Education and Hospitals decided to center a half-day co-sponsored program on Sunday, February 10, around discussion of the subject: "Graduate Medical Education for General Practice—1957." This program will be conducted as a symposium, covering the concept of what can be accomplished during the undergraduate four years of medical school. In addition, papers on the subject will be read, followed by a series of short, clear-cut statements by a group of representatives from the various specialty areas as to "What Should Constitute Graduate Medical Education for General Practice Today." There will also be a question-and-answer discussion period.

Sunday afternoon will be devoted to business meetings of the Advisory Board for Medical Specialties and the open meeting of Federation of State Boards of the United States.

On Monday, February 11, the program will be devoted to undergraduate medical education. At that time, Dr. Herman L. Weiskotten will deliver his final address as chairman of the council. Dr. Weiskotten, whose long and valuable experience in the field of medical education gives him a unique opportunity to present what he believes to be some of the lasting values, is retiring at the end of the year. A group of outstanding leaders will also present various approaches in an effort to answer: "Why Are Thoughtful Medical Educators So Restless and Dissatisfied Today?"

The Monday afternoon session will be devoted to problems of postgraduate medical education. This will include keynote statements on the importance of postgraduate medical education and the challenges it presents, together with reasons for the council's current interest. This will be followed by a series of interesting papers.

On Monday evening the Federation of State Medical Boards will hold its annual banquet, and on Tuesday, February 12, the conference program will be devoted to the Federation of State Medical Boards of the United States. Its program is centered on the theme: "Re-evaluation of the Licensing Examination."

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AMA RURAL HEALTH MEETING SET FOR MARCH

"Together We Build" will be the theme of the AMA's 12th National Conference on Rural Health to be held March 7-9 at the Brown Hotel, Louisville, Kentucky. Principal subjects to be discussed include: the need for frequent and thorough physical examinations; the impact of modern living; rural economics in relation to health, and the migrant labor problem. Time for discussion from the floor is being allotted. Sponsored by the Council on Rural Health, this year's Conference will begin at 10:00 A. M. Thursday, March 7, and wind up at noon on Saturday.

AMA SCHEDULES "NOMENCLATURE" INSTITUTES IN 1957

Plans have been announced by the American Medical Association to conduct two—and possibly three—short courses on the use of the Standard Nomenclature of Diseases and Operations during 1957. The first Institute will be held March 11-13 in Roanoke, Virginia, and the second August 5-7 in San Francisco. A third session probably will be scheduled in the fall. All of these three day meetings are conducted by the AMA as a special service to medical record librarians and others using the Nomenclature in the hospital, doctor's office or medical clinic. Lectures are given by Adaline C. Hayden, C.R.L., associate editor, on the theory, construction, basic principles, special and specific problems, and installation of the system. Anatomy lectures are given by Edward T. Thompson, M.D., editor of the *Nomenclature* and coordinator of professional services, hospital facilities, U. S. Public Health Service, Washington, D. C.

Registration for each session is limited to the first 100 applicants and is not restricted to registered medical record librarians. Anyone contemplating the installation of the system or already using it and employed as a clinic clerk, doctor's secretary or receptionist, nurse or physician may attend. Tuition is free. Applications should be sent to Mrs. Hayden at AMA Headquarters, Chicago.

Preliminary Program

RECENT CHANGES IN MATERNITY AND INFANT CARE

Wednesday, April 3, 1957

Winston C. Hainsworth, M.D., Willimantic, presiding

9:30 Practical physiology of premature and full term infant

Herbert S. Harned, Jr., M.D., assistant professor of pediatrics, Yale University School of Medicine

10:30 Coffee break

11:00 Respiratory diseases

Ira K. Brandt, M.D., research fellow pediatrics, Yale University School of Medicine

12:00 The premature and his family

Rose Coleman, M.D., instructor in pediatrics and public health, Yale University School of Medicine

1:00 Luncheon

2:00 Panel discussion: Care of the premature

Moderator: Henry Silver, M.D., associate professor of pediatrics, Yale University School of Medicine

Panel:

Herbert S. Harned, Jr., M.D., Yale University School of Medicine

Ira K. Brandt, M.D., Yale University School of Medicine

Edith B. Jackson, M.D., or Rose Coleman, M.D., Yale University School of Medicine

Miss Ernestine Wiedenbach, associate professor in obstetric nursing, Yale University School of Nursing

Miss Marilyn Goldstein, assistant instructor in clinical nursing (Children's Services), Yale University School of Nursing

Wednesday, April 10, 1957

Carl E. Johnson, M.D., New Haven, presiding

9:30 Comprehensive maternity care

Samuel B. Kirkwood, M.D., commissioner, Massachusetts Department of Public Health; clinical professor of maternal and child health, Harvard School of Public Health

10:30 Coffee break

11:00 The emotional and social implications of pregnancy, delivery, and postpartum periods

Edward C. Mann, M.D., assistant in psychiatry and assistant in obstetrics and gynecology, Cornell University Medical College

Discussion

1:00 Luncheon

2:00 Round Table: Socio-economic aspects of maternity care

Moderator: Charles Lee Buxton, M.D., professor of obstetrics and gynecology, Yale University School of Medicine

Panel:

Albert Snoke, M.D., director, Grace-New Haven Community Hospital, New Haven

Taylor Coleman, administrator, Sharon Hospital, Sharon

Louis F. Middlebrook, M.D., Connecticut Medical Service

Mrs. Deenah Stolman, director of Social Service, Hartford Hospital, Hartford

Discussion

3:15 Resuscitation of the newborn

Virginia Apgar, M.D., professor of anesthesiology, Columbia University College of Physicians and Surgeons

Place: Connecticut Light & Power Company, Berlin, Connecticut.

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SAVE THESE DATES

Final program will be mailed to hospital administrators, (2) chiefs of obstetrics, (3) chiefs of pediatrics, (4) directors of nursing, (5) maternity supervisors, (6) pediatric supervisors, (7) public health nursing agencies, (8) industries employing industrial nurses.

Registration blanks will accompany the final program.

For more complete information please contact the individual in your organization to whom this information will be sent or write directly to: Louis Spekter, M.D., director, Bureau of Maternal and Child Hygiene, Connecticut State Department of Health, Hartford, Connecticut.

THE YALE SUMMER SCHOOL OF ALCOHOL STUDIES

The School is organized to meet the needs of a number of categories of professional and non-professional people. Professional workers presently active in prevention or treatment of alcoholism, e.g., clergy, educators, physicians, case workers, psychologists, will have an opportunity to exchange experiences, review current literature and practices and re-define some of the principles they observe in practice. Enforcement and correctional officers, leaders in municipal and state affairs, traffic supervisors, personnel officers and foremen in industry, and others whose work requires a knowledge of alcohol problems will acquire a background of understanding of these questions through attendance at the School. Private citizens who wish to explore problems of alcohol as they are related to community life and social change will find their experiences at the School stimulating and challenging.

It should be understood that the School does not offer a program of clinical training in preparation for work in the field of rehabilitation of alcoholics. However, students who have a background of specialized skills appropriate for work in this field will find in the School opportunity to develop further some of their understandings and skills.

Further information on the Yale Summer School may be obtained by addressing the Registrar, Summer School of Alcohol Studies, 52 Hillhouse Avenue, Yale Station, New Haven, Connecticut.

NEW BOOKS IN REVIEW

CHILDREN OF DIVORCE. By J. Louise Despert, M.D.
New York: Doubleday and Co., Inc. 1957. 282 pp. \$7.50.

Reviewed by MILDRED H. JANUARY

The author's purpose in writing has been "to help save the marriages of today's children," and she dedicates her book to the children of the Payne Whitney Nursery School, who were her "teachers" for the ten years between 1937 and 1947. The work is addressed to parents and uses the informal and direct approach familiar in counseling and guidance. Its general tone is reassuring, since not legal

divorce, but emotional divorce is, both in the thoughts of the author and amply illustrated by her experience, the real destructive force in the lives of children. An advocate of a "common sense" approach in child treatment, the author hopes that practical advice may make it possible for parents who have not been successful in their marriage to make a success of the divorce process so far as the children are concerned.

Many clinical examples are given to illustrate the reaction of children to divorce. Statistics indicate that it is by no means the home broken by divorce which can be correlated with antisocial behavior. In the course of describing the reactions of specific children to the divorce situation the author is able to emphasize the basic needs of children, warn parents of the pitfalls in emotional development which may be encountered during divorce and the preceding as well as succeeding adjustments, and express the idealistic hope that divorce may be undertaken by the parents with the child's interest foremost. From wide experience with young children the point is clearly made that the child responds to the true feelings of his parents, even when it seems that he is not aware of the events about him. A child is able to survive almost any painful experience if he is sure of his family's love. Since during divorce this is precisely what no child can be sure of, the many clinical examples demonstrate the fact that for nearly all children the divorce of his parents is a very difficult problem and one in which he needs support and understanding, if he is to weather the inevitable tension.

The increasing divorce rate is considered in relation to modern life and perhaps the decreasing size of the family. Children of divorced parents are able to make as good a reality adjustment as other children, but the child's ability to accept the separation of the parents involves relinquishing many childhood needs and at times a premature embracing of adult standards of human limitation. Dr. Despert surveys the help available in the United States for parents and children in handling the divorce problem. It is rare to find the child's interests represented in the ordinary court procedure and counseling services of all kinds are the most likely resources for guidance and advice, often as part of the various service and social agencies, and of some schools and churches.

Since the preparation of children for life and marriage takes place first of all in the family, the author attempts to examine some of the points in family structure which may weaken a child's capacity to adjust to other individuals. No conclusions are drawn, but there seems to be an advantage in making it possible for the child to experience adult life, rather than separating him from it by the illusion of childish happiness. The final chapter in the book describes a happy family which has raised eleven children successfully and is engaged in raising a twelfth, a foster child. The idealistic portrait which is presented may be summed up simply in the fact that it is the personality of the parents that is of major importance.

This is a most readable book, written in nontechnical language, and beneath its reassuring tone it makes a serious point. Divorce is a situation which need not be a destructive family experience for children, but the avoidance of trouble requires love, interest and persistent effort on the part of everyone.

SPECIAL ANNOUNCEMENT TO PHYSICIANS OF
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Infarction

Treatment of Arrhythmias in
Myocardial Infarction

The Use of Digitalis in the
Treatment of Heart Failure in
Myocardial Infarction

Anticoagulants in Myocardial
Infarction

Diet in Prevention and Treatment
of Myocardial Infarction

Scientific sessions—10:00 a.m. to 12:30 p.m.
2:30 p.m. to 5:15 p.m.

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Luncheon
Special Entertainment

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Philadelphia, Pennsylvania

Clarence M. Agress, M.D.
Los Angeles, California

David Scherf, M.D.
New York, New York

René Bine, Jr., M.D.
San Francisco, California

Irving Brotman, M.D.
Washington, D. C.

John W. Gofman, M.D.
Berkeley, California

9:30 a.m.
12:45 p.m.
2:30 p.m.

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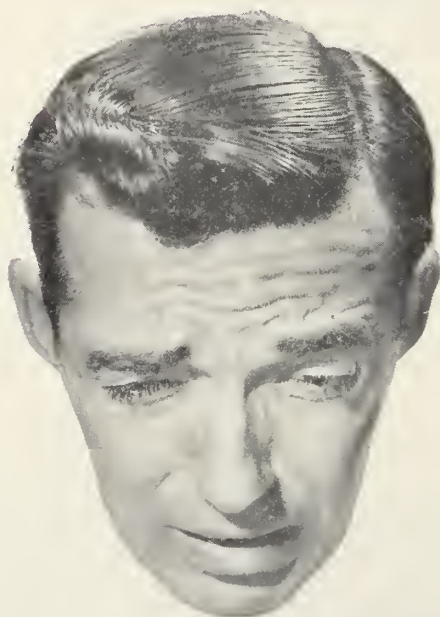
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THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. VIII. Ruth S. Eissler, Anna Freud, Heinz Hartmann, Ernst Kris, Managing Editors. New York: International Universities Press, Inc. 1953. 412 pp. \$7.50.

Reviewed by MILDRED H. JANUARY

The 1953 volume of a well established psychoanalytic annual is representative of the extensive psychoanalytic work being done throughout the children's field. Papers are from many different child study centers in the United States and one is from a center in London. Most of the studies are clinical in nature, and are the results primarily of clinical investigations, though they include certain theoretical formulations, but a few presentations are entirely theoretical. Several papers represent original contributions written for this volume, or the publication of work available previously only as lectures or papers at various meetings. The material of the book is divided into six sections, the titles giving indication of the scope of the field covered. There are three papers on "Problems of Early Development," three on "Psychosexual Development," four on the "Development of the Ego and Some of its Functions." There are six papers on "Ego Pathology," three on "Clinical Problems," and finally four on "Applied Psychoanalysis."

It is not possible to review the individual papers in detail. All are worth careful study, though they may not lend themselves to casual reading. All the contributions in the section on "Clinical Problems" struck this reviewer as being particularly distinguished, and the focus on therapeutic aim illuminates the theoretical ideas presented. Alpert and Krown discuss their attempts to treat within the nursery school framework a child in whom the impairment of ego development was especially severe. They recognize many limitations in accomplishment, in spite of the individual approach taken to the child, and concurrent work done with both parents. Impressed at first by the harm done the child by the many separations he had experienced, they revised their opinion as they became aware that the restriction in personality development had been in evidence before any separations occurred. Berta Bornstein traces the transformation and formation of symptomatology in a child of eight years who suffered from insomnia and fear of death, while Sara Kut presents the changes in the transference relationship observed during treatment of an intelligent eleven year old girl. Exposition of theory produces two technical papers on the subject, implemented by further clinical applications in other papers included in the section on "Ego Pathology." Certain childhood states of psychopathology can be understood only by reference to a pathological process in the course of ego development, and concrete examples are offered to illustrate the defects in capacities which are expected in the personality. The words "deviant, autistic" and "psychotic" have been used interchangeably to refer to the childhood problem, and occasionally the word "schizophrenic." Many defects in development can be traced to faulty personal relation to the objects of the surrounding world, though the cause for this remains obscure. The section on "Applied Psychoanalysis" follows the road of explanation of folklore and primitive behavior according to patterns of infantile thinking.

The process by which the mind differentiates the inner image from outside reality has occupied many of the contributors in part or as a primary goal, and the organization of the material into pertinent groups is especially to be commended since it makes it possible for the reader to

follow the avenues of exploration undertaken by different observers, in the attempt to predict and explain psychopathology, as well as various aspects of thinking. The emphasis on the functioning and development of the ego is as pertinent in understanding children as it has been found to be for adults and the opportunity for direct observation of mental processes in the formation of the personality is attracting increasing research effort to the child study field.

CHILD BEHAVIOR. By Frances L. Ilg, M.D. and Louise Bates Ames, Ph.D. New York: Harper and Brothers. 1955. 345 pp. \$3.95.

Reviewed by MILDRED H. JANUARY

As the foreword by Arnold Gesell indicates, the title of this newest volume by Frances Ilg and Louise Ames is that of a syndicated newspaper column written by the authors over a period of four years, with many additions, however, including material for a TV program devoted to children's problems. The authors' philosophy is that in order to understand a child it is necessary to understand his ways of growth, that many of the changes which will take place are determined from within, and are often normal or usual in occurrence. The book is designed to guide parents and covers in detailed fashion nearly every area which would concern a parent. Chapters 1 through 3 are general, but 4 through 18 discuss eating, sleeping and dreams, elimination, tensional outlets, fears, intelligence and retardation, sex behavior and sex interests, mother-child and father-child relationships, brothers and sisters, comics, television, movies, school, the ethical sense, discipline, and what to tell about Santa Claus, deity, death, adoption and divorce. Behavior which occurs in patterned forms, can be predicted, and there are many time tables of behavior at various age levels up to early adolescence. The authors do not feel that personality and ability, as distinguished from behavior, are predictable, but recommend careful observation.

Detailed description of the behavior of individual children is given, as is usual, in the authors' vivid and accurate manner, so that one recognizes that these are genuine observations and quotations from real children. The classification of the different types of behavior rests on statistical numbers, and the authors recognize that behavior and processes believed to be central in manifestation today may be found to be only superficial or a fringe reaction as the scientific exploration of wider and yet wider cause and effect proceeds.

Written from the point of view of the parent, who is often an harassed parent, the book is both optimistic and reassuring, perhaps a little too reassuring, written for a lay audience rather than intended for controversial evaluation. The authors and the Gesell group are pioneers in the field of exact, detailed, and adequate observation of children. The desire to generalize from descriptive data is an industrial hazard in the field of scientific research, and the pressure put on scientific workers to do so is very great, especially when human welfare is the goal. The lack of logic involved in the recommendation of a "conditioning device" for bed-wetting, and the philosophy of "constitutional psychology" that we behave as we do, that is, our personality is what it is, because of the way our bodies are built, is explainable if we realize that the authors are still reporting empirical data: that a number of cases of bed-wetting have in fact responded to something in the process of using a "conditioning device." The present reader might

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be expected to be troubled by attitudes which seem to imply that a child will probably grow out of his problems, that personality characteristics and psychological problems are due to some innate nature of man, or that the child may not have just and controllable cause for his behavior, good or bad.

One should remember, moreover, that there are parents for whom the hour or year spent alone with a child is welcome, one of the few genuine gifts in life, a pleasure which the child's process of growth will quickly render a thing of the past.

Noting that "there is one no more eager to learn about the welfare of his children than the American parent," the book specializes in practical suggestions. While these are in general directed toward adapting the child to the family situation from the point of view of the parents, the active approach serves the understanding of the child's point of view indirectly in that by recommending an approach geared to improvement with age the patience and understanding which results is still very effective. "There is no one answer . . . it all depends" is the attitude recommended toward many problems, yet the mixture of specific and separate treatment for symptoms contrasted with broader attitudes toward patterns of personality and growth may prove confusing, the emphasis on separate symptoms often serving to obscure the pattern and distract the parents from a recognition of the cause of the whole disturbance. The chapters on intelligence and retardation are excellent, balanced, and realistic.

TEXTBOOK OF UROLOGY. By Victor F. Marshall, M.D. New York, N. Y.: Paul B. Hoeber, Inc. 1956. 268 pp. \$5.50.

Reviewed by RICHARD J. SPILLANE

This volume is designed for undergraduate medical students and does not profess to be a definitive work of urology. It is based on material presented in formal lectures, and now supplants didactic teaching of this subject at Cornell University Medical College. The basic tenets of urology are offered in nineteen chapters with useful sources appended. The subject matter is well illustrated with interesting and informative drawings and diagrams which are effective for the student.

Dr. Marshall is a well recognized authority in the field. The teaching is thoroughly sound, and will serve the urologist as an excellent teaching guide and source of basic, concise, accurate and readable information.

TEXT BOOK OF MEDICAL PHYSIOLOGY. By Arthur C. Guyton, M.D. Philadelphia and London: W. B. Saunders Co. 1956. 1030 pp. 577 illustrations. \$13.50.

Reviewed by LOUIS H. NAHUM

The author of this text is Professor and Chairman of the Department of Physiology and Biophysics, University Mississippi School of Medicine. He states that it is not a reference book for physiologists but a text book for medical students. He could have added that it is a reference book for doctors as well as medical students and many cardiologists would benefit greatly from a perusal of its pages.

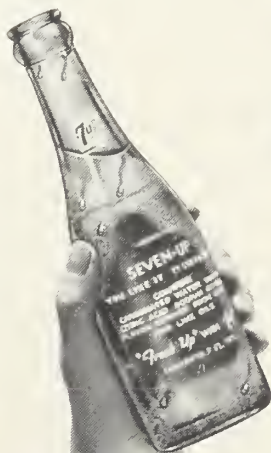
The first thing that strikes the reader is that Professor Guyton has written it all himself, an admittedly herculean task when one reflects on the rapid increase in knowledge and the great expansion that has taken place in each branch

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of physiology. It is clear that its chief aim is to appeal to the elementary student as he is being introduced to the complexities of bodily function. The approach to this must vary and depend upon one's philosophy of education. Some who think the origin and evolution of a principle can best supply the foundation for present day concepts will not find such information in this text. The idea of dynamics in the growth of our knowledge is not presented. There is a finality about this text that may give the student the impression that little remains to be solved, and complicated and as yet unproved approaches, such as, for example, vectorial analyses in electrocardiography, are presented with an uncomfortable finality.

On the other hand a medical student is hard pressed for time, feels comfortable when the subject is laid on the line so to speak. For him this text will meet an important need, not merely to learn from it present day physiology but to be able to review it at examination time. Many students, especially those interested in the practical rather than intellectual and cultural meaning of a science, are anxious from the start to see what physiology has to do with practicing medicine. For him and the doctor himself this book is ideal. It is simple, readable, introduces clinical disturbances in terms of their physiological derangements and gives reasonable explanations for a symptom. Because of this successful fusion of physiology and medicine, when the student enters the clinical years he can profitably return to this book for illumination and explanation.

The book is essentially didactic and somewhat of an expanded dictionary. Apparently the author after years of

experimentation in teaching physiology, to be exact 15 courses in 9 years, finally arrived at a text that "will convey the information necessary to the student in a way he can understand." There is little doubt in the reviewer's mind that the text is so constructed that it should give the student a sense of reward for his work.

The book consists of eleven parts. 1. Cellular physiology and an introduction to human physiology. 2. Nerve and muscle physiology. 3. The circulation. 4. Body fluids and the kidney. 5. Blood cells, immunity, clotting and blood types. 6. Respiration. 7. Neurophysiology. 8. Special senses. 9. Digestion, metabolism and energy. 10. Endocrinology. 11. Radiation. These eleven major sections consist of 75 chapters. After each one may be found a long list of pertinent publications. It is clear the author has spent much effort in choosing these references. They are the most recent ones and if one wishes to delve a little further back in the origin and evolution of an idea one would have to resort to the bibliography of the references. Thus, for example, although the idea of spread of excitation through the heart is presented almost out of Lewis's classic work on electrocardiography, his name is not found in the references.

The arrangement of the sections is naturally the result of the author's own experience in his repeated experiments with the presentation of his course. There are some who believe that the energetics of cells, reflex control of bodily functions as epitomized by the mechanisms of homeostasis are the foundations of physiology. It is difficult to convey the meaning of function to the student under any circumstances. But the "wisdom of the body" lies in the manner

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in which it is organized to maintain its internal environment and for this reason cellular energetics, reflex mechanisms and other regulatory mechanisms could perhaps illuminate the whole subject for the student.

As is to be expected there always must remain minor bases for differences of opinion. The concept that the normal lung is an insulator of heart currents is not tenable any longer. The view that a wire on the left leg is a direct electrical connection to the lower end of the heart is an over simplification. The term "rate of rhythm" would require "rhythm of rhythm" to describe irregularities. For this reason rate and rhythm are usually considered as separate entities. In Figure 192 Lead I and III are probably simultaneous but Lead II is not. The concept of right and left ventricular contributions to the electrocardiogram could be fruitful. The importance of heart surface potentials to the electrocardiogram is basic and could help the student to understand better the interpretations placed upon the electrocardiogram.

These are minor in the overall excellence of the clear exposition. The first year student will feel indebted to Professor Guyton for this text book. Nowhere can he more readily find a definition, a description of a concept in physiology, and the relation of these to medical problems as clear and well presented.

The book is printed in two columns per page, and this makes the print large and reading is easy and not fatiguing. Only an occasional typographic error can be found and this speaks highly for the perfect editing.

It should be widely distributed for it could profitably form an important part of any medical student's intellectual development in physiology and medicine.

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The CONNECTICUT STATE MEDICAL JOURNAL

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PSYCHIATRY AS A CAREER

WILLIAM B. TERHUNE, M.D., *New Canaan*

PSYCHIATRY, a relatively new speciality in the long history of medicine, offers certain advantages to the young physician that are not found in some of the older specialties. The need for psychiatrists is great—indeed, it is urgent. The opportunities for advancement are ample, and the financial returns compare favorably with those in other leading medical fields. The most important advantages are that psychiatry by its very nature promotes in its disciples continuing personal growth, and offers a unique opportunity for service. Thus it brings to those who practice it deep abiding personal satisfaction.

Like other specialties, psychiatry requires graduate training following the regular medical internship. The young doctor who is trying to arrive at a decision about the choice of psychiatry as his specialty must be willing to undertake this additional training, which calls for from three to five years of study and clinical experience. He must also consider carefully whether he has the personality traits and characteristics that are necessary for constructive work in this field. In his self assessment, he should seek counsel and guidance, preferably from psychiatrists in his medical school or in the hospital where he has served his internship.

ESSENTIAL PERSONALITY TRAITS

An attempt was made some years ago to estimate medical students' ability to adjust to medical education and hence their ability to function successfully as physicians. It was found that the following characteristics gave the best chance of success: adequate intellectual capacity, ability to communicate, self reliance, maturity, originality, intellectual curiosity, persistence in achieving goals, socially acceptable aggressiveness, and sensitivity to the feelings of others. The emphasis, it will be noted, is on personal relationships. It is skills in these relationships, and the capacity and desire to develop them to their

The Author. *Medical Director, Silver Hill Foundation, New Canaan, Connecticut; Associate Professor of Clinical Psychiatry, Yale School of Medicine*

SUMMARY

Psychiatry is recommended as a career, economically sound and professionally satisfying, for the physician who is intellectually, ethically and spiritually adapted to this field. Detailed qualifications of a good psychiatrist are outlined and the many areas and subspecialties within psychiatry are described. The various types of psychiatric practice, such as State hospital, community clinics, teaching and research, and private practice are all discussed. Finally, the extremely important consideration of the patient's finances is dealt with frankly and convincingly.

greatest extent, that are essential for the psychiatrist. As we come to understand the close connection between somatic and emotional illness, we can also understand why the attributes empirically listed above as needed by the general practitioner are also needed in intensified form by the psychiatrist.

The all important personality factor in psychiatry is rapport, the establishment of a relationship of understanding, respect and affection between patient and doctor. Rapport, the foundation stone of psychotherapy, is a mutual feeling; psychotherapy is not something that is done *by* the therapist *to* the patient, but something that is established by *both* of them. The psychiatrist must have the capacity for making this happen.

He must also be an alert, inquiring person who thinks in terms of why, what, how, and when—to paraphrase the journalistic precept about who, what, when, and how. Why, the psychiatrist must ask himself, is this person as he is? The elusive factors

must patiently be sought; the obvious ones must be discarded. With this type of inquiring mind, the psychiatrist gradually helps the patient, too, to think in terms of why. The psychiatrist also concentrates positively on what is right with the patient, what his assets are and how they can be mobilized to help him. Since timing is vitally important in psychotherapy, the psychiatrist must know intuitively when to take specific action—when to ask a question or make a statement, when to see relatives, when to manipulate the environment, and, above all, when to terminate treatment.

In large measure such specific manifestations of the alert, inquiring mind come with experience. The psychiatrist, however, must have the necessary innate characteristics at the start. Given these characteristics, and a willingness to undertake the arduous program of training for certification as a psychiatrist, the young physician can with confidence choose psychiatry as a career. What can he expect from his chosen profession?

PERSONAL GROWTH

Let us consider the intangible and, to me, the most important elements first. The very nature of psychotherapy encourages the physician's spiritual growth, and develops in him qualities of patience, persistence, and thoroughness. The treatment of mental illness is a long process, during which the psychiatrist is beset with doubts as to the efficacy of what he is doing. He must remember that quick "miraculous" mental healing does not last, and that the results of speedy so-called "cures" are dissipated as rapidly as they are attained. In contrast, the results of good psychotherapy come slowly; they are satisfactory and permanent because they are built upon a firm foundation. The psychiatrist must have faith in what he is doing. He must not be easily discouraged. He must cultivate a sense of humor, so that he can see things in proper proportion. Often he must be able to laugh—in order not to cry.

In learning all these things, he will grow spiritually. He will be able to take satisfaction from the fact that he is devoting himself to helping others and doing his part to meet a need that must be filled as rapidly as possible.

How great this need is cannot be measured quantitatively. In hospitals, where statistical data are at hand, we know that thousands of additional psychiatrists are needed, and that the need far exceeds the number available. Little is known about how many

are needed for the many nonhospitalized persons who should have, but cannot get, psychiatric help. In addition, the community calls upon psychiatrists for advice and counseling in many diverse fields not directly related to the treatment of individuals. It is clear that psychiatry offers an opportunity for service with its satisfactions and rewards.

PROFESSIONAL DEVELOPMENT

The many subspecialties and special areas within psychiatry make it possible for the psychiatrist to work in a field that particularly interests him. Thus he can develop professionally and function effectively. Whatever his particular interest, however, he must first and foremost be a well rounded physician—a good doctor, and then a good psychiatrist. The American Board of Psychiatry and Neurology recommends "a three-year, full-time program" at institutions approved by the Board and the Council on Medical Education and Hospitals of the American Medical Association. This recommendation, in effect a prerequisite to certification by the Board, has standardized psychiatric training, and raised the level of competence in this discipline.

With the completion of training, the psychiatrist can focus on the particular area which he finds most attractive. A brief discussion of a few of these areas follows.

Child psychiatry. Some training in child psychiatry is a necessary and integral part of general psychiatric training, for the psychiatrist cannot understand adults unless he first understands children. Thus the general psychiatrist should be able to handle many of the problems of childhood. There is, however, need for psychiatrists specially trained to deal with the more difficult cases of childhood maladjustment and mental illness. The therapeutic techniques obviously differ from those used with adults, although they are based on the same fundamental principles. In contrast to the slow course of treatment with adults, the results are relatively quick and sometimes spectacular. For psychiatrists who are drawn to this type of practice, the work is interesting and rewarding.

Administrative psychiatry. The accrediting of mental hospital administrators, recently initiated by the American Psychiatric Association, has done much to give this field status. Training courses are now available in several universities and teaching centers. These developments are offsetting the former erroneous view that administrative psychiatry

is totally divorced from clinical psychiatry. Imaginatively understood, administrative psychiatry involves all the mechanisms employed to provide the patient with proper treatment, and to manage him adequately from day to day, so that he may receive the maximum benefit from treatment. In essence, it is concerned with the management of people, with planning, and with communication. It is one of the newest and most satisfying opportunities in the general field of psychiatry.

Industrial psychiatry. Industrial physicians are becoming more aware of the problem of psychoneuroses in industry, of their effects on efficiency and their role in absenteeism. As this awareness increases, the need for industrial psychiatrists increases. This phase of psychiatry focuses on the part played by the job and conditions of work in maintaining or disrupting mental health, the meaning of work to the individual's self image, and the influence of social, economic, and cultural factors on mental health. The industrial psychiatrist has manifold duties. Among them are: short-term therapy with patients coming to the medical office; diagnosis and help in the disposition of patients too ill for adjustment on the job; formulation of policy as it influences group effectiveness and morale, and training of personnel and line supervisors in mental hygiene principles. This is a relatively new and challenging field in which psychiatric services will be increasingly needed.

Military psychiatry. It has been succinctly said that this area of psychiatry deals with normal individuals in abnormal conditions. Because many factors in the military environment are not found in civilian life, military psychiatry is markedly different from civilian psychiatry, and ordinary criteria for diagnosis and treatment are not always adequate. Whatever the reasons, it has been found that physicians trained in child psychiatry and also those with short-term (two year) psychiatric training rather than fuller preparation seem to function most effectively in this field. Hopefully, we shall not be faced in the future with the necessity for military psychology under combat conditions. Even in a peacetime military milieu, however, psychiatrists are sorely needed and can make useful contributions.

Forensic psychiatry. General psychiatric training includes, or should include, familiarity with commitment procedures and the state laws governing the control of psychiatric institutions, and instruction in basic courtroom procedure relating to the

presentation of evidence and courtroom demeanor. The psychiatrist who specializes in forensic psychiatry usually enters the field after some years of general experience. He will seek training in the law; he should have a quick mind, and be able to handle himself effectively in court.

Forensic psychiatry is a major influence in shaping the public's attitude toward psychiatry in general. It can do much toward solving the problems of cleavage between psychiatry and the law which stems from fundamental differences in approach. For example, belief in free will is the chief cornerstone of criminal law, whereas psychiatry is aware of the mechanisms that limit free choice of action. Permissiveness is an integral part of psychiatric thinking, whereas law, especially criminal law, is the relentless dispenser of punishment. Much progress, however, has been made in improving the relationship between psychiatry and the law. The practice of forensic psychiatry will speed up this progress. It is a large field that is increasing in importance, a field in which the psychiatrist may be of great service. It should be noted that he can make money in it—and also lose his reputation.

Psychoanalysis. The term psychoanalysis has a threefold meaning: (1) a method of investigating human behavior, (2) a body of theories concerning the data obtained by this method, and (3) a therapeutic technique. It is this third meaning that constitutes the subspecialty of psychoanalysis. This type of therapy should not be lightly entered into by either the psychiatrist or the patient, for it is a disturbing experience, not suitable for all types of mental illness.

Aside from its use as a therapeutic technique, psychoanalysis helps the physician understand the fundamental reactions of human beings, their psychodynamics, and thus promotes his empathy and his ability to help his patients. Good psychotherapy presupposes some knowledge of psychoanalytic theory and practice. Thus, in some instances, it is a desirable part of general psychiatric training. The Conference on Psychiatric Education, held under the auspices of the American Psychiatric Association and the Association of American Medical Colleges in 1952, considered the role of psychoanalysis in psychiatric training and concluded:

(1) It is not necessary to be psychoanalyzed in order to develop competence as a psychiatrist, including competence in psychotherapy and psychodynamics.

(2) It is highly desirable that some persons should receive a personal psychoanalysis and psychoanalytic training because of the contributions which psychoanalysis may make in varying degrees to the personal adjustment of the psychiatrist, to his skills as a therapist, and to his understanding of the basic science of psychodynamics. For those who are to practice the specialty of psychoanalytic therapy, such psychoanalytic training is considered a necessity.

Despite these conclusions, a majority of psychiatric residents are eager to have full-scale training analysis. Because of the difficulties encountered in obtaining them, a short-term modified form is advocated in some training centers and is being developed. Acceptance of this modified form of analysis is gaining ground.

I include under analysis as a therapy that form of psychiatric treatment known as re-education—a retraining of patients in the understanding of life and the principles of living. For this form of therapy, as for general psychotherapy, the psychiatrist must be familiar with and use many of the accepted techniques of psychoanalysis.

TYPES OF PRACTICE

Just as there are many areas and subspecialties within psychiatry, there are also many types of practice from which the psychiatrist can select one most suited to his interests. Some types are chiefly valuable as stepping stones to other work; some offer satisfying permanent careers.

State hospital service. The State mental hospital was formerly a place designed primarily for custodial care, housing thousands of mentally ill who had little or no chance for recovery. Set apart from the community, neglected, and stigmatized if thought of at all, the State hospital was shunned by keen and forward-looking members of the profession. Today the concept of the State hospital is radically different. It is a place for constructive treatment and recovery. Ever greater numbers of patients are discharged and take up their lives again as respected members of their communities. The hospital itself is finding a place as a community resource, a trend which is reflected in the development of community treatment centers integrated with the hospitals. These centers provide care for nonhospitalized patients who are able to live and work in the community while under treatment. All these developments make State hospital service a

challenging and rewarding field for the psychiatrist. He has an opportunity to work with a wide range of case material, and can acquire a broad eclectic view. His professional status is high and his position in the community is secure.

The advantages of State hospital service are indicated by the number that are approved for residency training. Most leaders in psychiatry today were trained in this service. In addition to offering good training, the State hospitals offer good permanent careers in psychiatry.

Veterans Administration service. Some VA hospitals are devoted almost entirely to neuropsychiatric patients; others are general hospitals with some neuropsychiatric beds. Both types offer approved residency training in psychiatry, and ample opportunity for administrative and clinical careers. This field has excellent professional status and a challenging opportunity for service.

Care of the mentally deficient and epileptic. In the past the medical profession has been pessimistic about the mentally deficient, feeling that little could be done to improve their status. Fortunately this view is changing, and it may well be that in the foreseeable future we shall be able to improve the treatment of this group, as we have improved the treatment of the mentally ill. The psychiatrist with vision, courage, and a pioneering spirit has an opportunity to make substantial contributions in this challenging field both with individual patients and in special institutions for their care.

Psychiatry also has much to contribute in the field of epilepsy. Formerly the view was that the best that could be done for those afflicted with this "hopeless" illness was to care for them in special institutions. Today medication has cut down, and even completely controlled, seizures in about 80 per cent of cases. The patient must, however, be under the continuous care of a physician, and generally needs supportive psychiatric treatment because the epilepsies are psychiatric disorders of mood as well as organic neurological entities.

Community clinics. As State hospital services expand and reach out into the community (as noted above), many of the present drawbacks of psychiatric work in community clinics will disappear. Today most community services in psychiatry are limited to child guidance and parent education. There is frequently little or no contact with other physicians and no hospital affiliation. As a result the psychiatrist is likely to suffer from professional

isolation. An added difficulty is lack of adequate financial support. It may be expected that these disadvantages will be mitigated in the near future. Psychiatric work in community clinics will then be valuable as a permanent area of activity. At present it is esteemed chiefly as training experience and because of the opportunity offered to get a foothold in the community.

Teaching and research. These fields offer well nigh unlimited opportunities for satisfaction and service for those who are drawn to them by temperament and inclination. They are, in general, carried on hand in hand with clinical activities. The psychiatrist who chooses a teaching career must enjoy the academic atmosphere. He must also be able to work as part of a team with his colleagues in other specialties, for the trend in medical education is ever more integration and the lowering of departmental barriers.

The able teacher and research worker advances rapidly, and his services are always in demand. An added advantage is that ranking members of a faculty are usually able to attend professional meetings at home and abroad, and can accept temporary governmental appointments of distinction. Another advantage is that it is an easy step from a teaching position into successful private practice, since the teacher is assured of the respect of his colleagues and members of the community.

Private practice. There seems to be no limit to how many privately practicing psychiatrists a community can support. No matter how many there are in relation to the population, they are all "too busy." One of the criticisms often made about psychiatrists, especially those in private practice, is that they are too busy to attend medical meetings, to do hospital and outpatient work, to attend hospital staff conferences, or to accept new patients, except in cases of dire necessity. Like all doctors, the psychiatrist in private practice must somehow find time for all these activities. Otherwise he merits the censure of both the laity and his medical colleagues.

Most psychiatrists in private practice work from 6 A. M. to 10 P. M., with little time to eat, exercise, or play, little time to be with their families, and/or to develop outside interests. In addition to the many hours spent with patients, they must find time for long telephone talks and voluminous correspondence in connection with the treatment of patients. They need understanding and mature wives, who will help

them make the most of precious moments of personal life. And they usually have such wives.

The psychiatrist in private practice must deal with all forms of emotional illness. He treats not only the psychoneurotic but also the mild psychotic who can continue, with his help, to live and function in the community. He will be called upon to care for borderline mental defectives, for epileptics, patients with arteriosclerosis, and so on. Thus his practice is varied and challenging.

FINANCES

The diplomate in psychiatry will find that his earnings will compare favorably with those of other specialties. State hospitals pay from \$6,000 to \$15,000 a year, with maintenance. The psychiatrist who enters this service can be assured of a comfortable income, an opportunity to save money, and a pension at an early retirement age. Economically it is a good proposition, better than that in many other fields. State supervisory positions pay up to \$20,000, without maintenance. In most states the Commissioner of Mental Health receives a salary larger than that of the Governor.

Teaching usually pays from \$4,000 to \$20,000, without maintenance. It is infrequently possible to engage in private practice to augment this income.

In Veterans Administration hospitals men just out of medical school receive about \$6,000 per year, and salaries run up to \$15,000 or more, with pensions at a reasonably early age.

Private practice income averages from \$20,000 to \$60,000 a year. Psychiatrists in this group have been accused of demanding high fees, and a few have doubtless been guilty of the practice. Psychiatric fees in general, however, are the least expensive medical specialty service that a patient can buy. They may seem high because the patient is not accustomed to buying as much of the doctor's time as he does in securing psychiatric examination and treatment. I doubt if any other specialists receive as little as \$25 an hour.

Financial remuneration is important not only to the physician, but to the patient. Some doctors say that the patient's finances are not their business, yet economic factors often play an important part in the patient's illness and recovery. Therefore the doctor, and particularly the psychiatrist, must understand basic economics as related to health and disease. He should know what the patient is able to spend in trying to get well, and help him to spend his

money wisely. The patient should not be left with a greater financial burden than he had when he entered treatment. All over the country patients have been treated by physicians who have given no thought to their patient's ability to pay, and by the time they get to a psychiatrist their funds are exhausted and their illness usually enhanced.

When planning a method of treatment, the psychiatrist should consider not only the physical and emotional strength of the patient, but also his financial strength. He may prefer to cure a depressed patient by the use of psychotherapy which would take three or four months, placing him in debt and perhaps causing him to lose his job. To save pocket-book, job, and even life, he may be forced to recommend electroshock. But he should not forget that electroshock makes subsequent good psychotherapy and character building almost impossible.

At the beginning of treatment it is well to discuss what the approximate expense of treatment will be, and to consider the patient's means, his assets and liabilities. He must not exhaust his assets. It is amazing how comforted the patient is when the cost of treatment is clearly set forth. A good method is to set down on a card in the patient's presence what the charges will be, before treatment is undertaken. This procedure is recommended as helpful for the patient and financially advantageous for the doctor. People who want to know the cost before beginning treatment are more likely to pay their bills.

Every psychiatrist, like every other physician, should carry a substantial amount of free work, and devote one fourth of his time to such work with patients in either office practice or clinics. As both physician and good citizen he should also devote part of his time to community projects, lectures, and service to civic organizations.

CONCLUSION

In concluding this survey of psychiatry as a career, I want to emphasize two points:

1. The good psychiatrist must have a personal religion. It may be only the "religion" of science. He may be an agnostic insofar as belief in God is concerned, but he must have some valid way of life and self discipline that helps his thinking, guides his conduct, and provides a reason and purpose for living. A psychiatrist must be a good, kind, warm, generous person. Christ was the prototype of the Great Psychiatrist.

By its very nature science is cold, and it changes so rapidly that those who regard it as a religion come to feel that they serve a rather impermanent god. The psychiatrist who believes in neither God nor science is a dangerous person, and should not be allowed to practice medicine. There are such doctors, and they are themselves lost souls.

2. Most psychiatric patients are dominated by fear and/or anger, and the only antidote for these two destructive emotions is love. The majority of psychiatric patients—in fact, most people—do not understand true, unselfish love. Often their only chance of learning about it is through their relationship with a physician who, by precept and example, and the establishment of rapport, can teach them to use unselfish love in all their actions. Love is not known instinctively. It must be taught. This is, perhaps, the psychiatrist's most important contribution to his fellowmen.

Summarizing the ideas and facts presented in the foregoing pages, I recommend psychiatry as an economically sound and professionally satisfying career for the physician who has an inquiring mind, personal integrity, and consecration to a life of selfless service efficiently rendered. In psychiatry such a person will find the opportunity for an honored significant life, dedicated to the task of helping his fellowmen. The doctor who becomes a good psychiatrist will also grow and mature spiritually, and thus have the only true wealth any one can possess.

THE TREND AWAY FROM CLINICAL MEDICINE

MARCUS BACKER, M.D., *Bridgeport*

IN our age of technological priority, mechanical devices often replace manual labor. Little is lost and much is gained by substitution of the machine for human muscle. Is this equally true for modern technical aids in the practice of medicine? Do they replace the need of bedside observation, clinical skill, and experience? Can we rely on even our best laboratory facilities to the exclusion of deft and intent clinical inquiry?

USELESS LABORATORY TESTS

To the older physician trained by the heirs of the Oslers and the Chvosteks these are, of course, rhetorical questions. Many others indiscriminately consign differential diagnosis to methodology without the benefit of clinical scrutiny. Who has not seen some long lists of incoherent laboratory orders which show no leading thought? They display lavish routine, not pertinent search.

Such sights make one wonder. Are some of the often needless hospital admissions meant to give up clinical ken for the help of the hospital laboratory? Unfortunately the maze of tests may fail to include exactly that test which might be most revealing. Moreover, the best of laboratory methods is not always foolproof. Only meticulous examination of the patient shields against misleading laboratory error.

This was illustrated at this hospital several months ago. By way of contrast, a correct clinical diagnosis of gastric cancer was not disclosed by x-ray but was confirmed at autopsy. The x-ray findings had not been entirely satisfactory because the patient was not cooperative, but they were thought to show thickening of the gastric rugae. At autopsy the growth was found in the middle of the lesser curvature, measured about 4.5 cm. by 6 cm., and was contiguous with a large mass within the omentum.

In 1863 Leonard J. Sanford, as professor of anatomy and physiology in Yale College eulogized in his inaugural address³ his deceased predecessor, Profes-

The Author. *Active Consultant in Medicine, St. Vincent's Hospital, Bridgeport, Connecticut*

SUMMARY

In the teaching and practice of medicine the clinical approach must regain full emphasis. Relegating the patient to the various laboratories instead of the clinical approach is neither a fair nor a salutary exchange. The excessive routine "work-up" without clinical guidance is detrimental to the cultivation of clinical competence, and it may be misleading or useless. It should be replaced by judicious choice of clinically germane laboratory procedures.

sor Charles Hooker. He praised him as "a close and accurate observer of symptoms" who "understood their bearing and indications" and "quickly perceived the varying features and phases of disease." Less than sixty years thereafter, one of this country's illustrious surgeons deplored a growing change which placed undue dependence on the laboratory. The great John B. Deaver¹ asked in 1922: "Is not that which we may recognize with our five senses just as scientific, just as dependable, as that which is disclosed by a complicated laboratory method full of all possible sources of error?"

TREND AWAY FROM CLINICAL INVESTIGATION

Such voices of concern with this growing trend away from the clinic to the laboratory, instead of its profitable use as needed, have been heard repeatedly in the last two decades. Very recently, the then president of the Connecticut State Medical Society, Dr. H. M. Marvin,² observed that "physicians have placed less and less reliance upon the deductive reasoning and trials of therapy that formerly aided in reaching correct diagnoses." He pointed out that "diagnostic testing is sometimes carried to unnecessary lengths" and objected to "shotgun testing" as a result of which "physicians may become increas-

From the Department of Medicine, St. Vincent's Hospital, Bridgeport, Connecticut

ingly dependent upon laboratory tests, rather than upon their observations of patients."

Are these words exaggerating and unduly alarming? Not when an intern labels a classical picture of mitral stenosis as "arteriosclerotic heart disease" and the associated congestive cough promptly stopped by digitalis as "viral tracheobronchitis;" not when too many hospital records show a flagrant neglect of adequate history taking; not when a middle-aged man losing weight, appetite, strength, and a lot of blood from a duodenal ulcer remains a "hypertensive problem" because he does have moderate hypertension but does not tell and is not asked about his tarry stools until questioned by the consultant.

IMPORTANCE OF HISTORY AND PHYSICAL EXAMINATION

Every practicing physician knows how some patients will not of their own accord report even the gravest symptoms. Such patients must be questioned about symptoms suggested by their physical appearance and by their complaints. Here, failure to gain an over-all impression, disregard for the value of symptomatology, and disinterestedness in the patient's past history are conducive to serious errors of omission. All mensural determinations notwithstanding, the clue may still be missed.

The above mentioned man's external appearance had made no impression. His poor color, half sunken cheeks, ghost-like face of debility, the obvious weight loss, had not prompted inquiring into their true cause. The weakness and dyspnea of late origin were viewed as cardiac manifestations of his hypertension.

Relevant interrogation soon revealed past treatment for a peptic ulcer which gave him "no trouble during the past year." The patient admitted recent pitch black stools each day. As was expected, the blood count traced the weakness and shortness of breath to severe anemia, and the x-rays brought to light the source of the hemorrhages.

The following is another example of what may result from failure to observe the patient's external appearance, to grasp the meaning of his symptoms, and to gain a lead by purposeful questioning. This middle-aged man had been treated by a noted physician primarily interested in metabolism research at a great institution. During the many months under his care the patient underwent numerous tests, and was treated with phenobarbital. On one occasion he presented his old complaints to the

present writer: fatigue, loss of ambition. His bearing was tardy, his countenance apathetic, dull, and doughy. He was asked the usual few questions in connection with myxedema. The answers were all affirmative. The patient was sent back to his doctor with the tentative diagnosis for laboratory confirmation and treatment. Faced with a conspicuously low level of the serum protein bound iodine, his physician now prescribed thyroid medication.

THE ROUTINE WORKUP

Obviously, even the most competent examiner's attention may be bound for error if he ignores clinical medicine and routinely relegates the patient to a so-called workup. For this routine, void of a guiding impression to be derived from clinical considerations, is not always a safe diagnostic approach. It may prove to be a very comprehensive, yet sterile, effort.

The mere concept of a "work-up" ahead of seasoned clinical investigation tends to detract from teaching to observe and correlate diagnostic tests. Infectious mononucleosis, for example, would not become apparent from a "work-up" unless it included a Paul-Bunnell test. Yet no "work-up" can possibly include all or most of the available tests. We learn to suspect infectious mononucleosis from the examination of the patient, subject to confirmation by the test. Similarly, not every patient's blood chemistry needs to be searched for evidence of Addison's disease as a part of the "work-up." We learn to gain the impression of Addison's disease from the clinical picture, subject to suitable tests thereafter.

The orientation we are facing departs from the time-honored approach of the founders of medicine who had no special tools. Has not Pfeiffer described what is now known as infectious mononucleosis nearly half a century before the discovery of the Paul-Bunnell test? Has not Addison's classical work preceded even the remotest notion of electrolytes?

PROPER USE OF LABORATORY TESTS

Undoubtedly the laboratory does at times establish a diagnosis not even thought of by the clinician. For instance, pathognomonic rib notching has more than once been found in x-ray plates requested without any suspicion of coarctation of the aorta. However, such occurrences only show up regrettable clinical omissions. Simple palpation of certain regional arteries, blood pressure comparisons in the upper and lower extremities should not be omitted

in hypertension of doubtful etiology, especially in young people. When such simple caution is observed, coarctation of the aorta is diagnosed at the bedside first, and in the x-ray department afterwards.

Finally, there are some rather cryptic ailments for which no laboratory test is available. Here, nothing but clinical skill and a sense of direction will help. Otherwise, such patients may be hospitalized repeatedly and still be perplexing despite all obtained laboratory data.

An elderly man was admitted to this hospital for the second time within several months for the same reason. A year and a half previously he suddenly became dizzy and fainted. Before and after that brief episode he felt well. Since then he fainted twice more, but was not dizzy before fainting. Again, nothing else was remarkable about him during the entire interval except for his great concern about these events.

His physician quite correctly diagnosed cerebral and cardiac arteriosclerosis for which there was manifold evidence. He blamed the arteriosclerotic process in general for the syncope spells. The possibility of carotid sinus hypersensitiveness was considered but no conclusive phenomena were elicited on local pressure. The laboratory data included a red blood count, sedimentation rate, the levels of the fasting blood sugar, serum chlorides, sodium, potassium, and urea nitrogen. The glucose tolerance was tested. Electrocardiograms were taken. The

usual urinalysis and blood counts were done. Complete x-ray examination was made. None of the findings answered the question: what specifically caused the fainting?

In the course of examining the patient in consultation, a disparity was noticed between the common carotid arteries on each side of the neck at the bifurcation of the vessel below the mandibular angle. On the right side a little aneurysmal bulge of the artery was found in the location of the carotid sinus. Moderate digital pressure was then exerted over the right carotid sinus, with the patient standing on the floor. This induced almost immediate faintness and forced him to fall back into the prepared arm chair. The patient observed the resemblance between this experience and his fainting spells. Simple reproduction of the mechanism disclosed right carotid sinus hypersensitiveness.

CONCLUSIONS

There has been a growing neglect of the clinical approach in medical practice. Conversely, modern laboratory facilities have been unduly abused. Clinical guidance should come first, wisely chosen laboratory tests should follow.

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SEROUS OTITIS MEDIA AND DEAFNESS IN CHILDREN

GREGORY K. DWYER, M.D., *Norwalk*

Insidious hearing loss in children, with or without ear pain, is becoming far more prevalent today.¹ This condition, if neglected, may well become permanent.² Even today well trained otolaryngologists often miss the etiologic factor, namely, serous otitis media.³ The latter has replaced the previous high incidence of acute purulent otitis media. Antibiotic therapy has no doubt been a large factor in the picture, but certainly a change in the virulence and/or invasiveness of the organisms has played an important roll as well. More intelligent understanding of the problem by pediatricians and even parents has helped to bring this problem to the fore.

Serous otitis media was recognized as far back as 1867 by Politzer,⁴ but because of the then more serious complications of middle ear infection, not enough attention was given this entity.

Serous or catarrhal otitis media may be described as an exudate and/or transudate in the middle ear caused by obstruction of the eustachian tube by edema, infection, or lymphoid tissue.⁵ Campbell⁶ and King⁷ believe allergy plays a major factor as evidenced by increased eosinophils in the nonrecoveries. Contrarily, Robison⁸ and Hoople⁹ found not only sterile fluid, but no laboratory evidence to support allergy, bacterial or viral infection. Harcourt¹⁰ published similar results with thirty-nine cases at Walter Reed Hospital. Samuels¹¹ pointed out increased air travel as a causative factor, and Lindsay¹² noted that extreme conservatism of pediatricians regarding tonsillectomy and/or adenoidectomy was important in this regard.

The history is usually that of repeated bouts of "otitis" with pain or fever or deafness, in any combination. Usually an antibiotic has been given, after which the symptoms subside, only to recur shortly after stopping medication. In older children the complaint may be simply a plugged feeling, or "water in my ear," not unlike the presenting symptoms of impacted cerumen.

Perhaps the most constant feature in these chil-

The Author. *Assistant Clinical Professor of Otolaryngology, Yale University School of Medicine; Attending Staff, Norwalk Hospital*

SUMMARY

Chronic serous otitis media has become a major factor in insidious progressive deafness in children. Awareness of this is fortunately becoming more prevalent among both pediatricians and otolaryngologists. Physicians are urged not to delay treatment too long by interim antibiotics, but to have the patient checked for possible myringotomy. The latter treatment has been well substantiated by many reports, and the recent experience of this author adds to the evidence.

dren is a strongly negative Rinne test (bone conduction greater than air conduction), or an equal Rinne. The drums are usually full to bulging, white or tawny in color, occasionally even retracted, and rarely may show a fluid level. Inflation of the eustachian tube often produces visible bubbles behind the drum. It must be remembered that early hearing loss in children is often missed because of their normally acute hearing (10-15 decibels greater in the normal child than the normal adult), or because parents feel it is simply inattention on the part of the child.

McLaurin¹³ pointed out that in the acute stage, serous otitis media is frequently self limited, which may account for the "cures" of one shot of penicillin or some warm, oily ear drops. Treatment of the chronic or recurrent type is primarily directed toward removal of the fluid by myringotomy and aspiration. Politzer⁴ always maintained "myringotomy is best." Needle aspiration alone in the office is not adequate in children, particularly from a psychic standpoint. Hoople¹⁴ in his excellent review pointed out that the fluid is thick, gluey, tenacious, and viscid—a typical exudate with a low protein, but it may be thin and serous with a high protein, if a

true transudate. The aspiration must be carried out by spot suction or Siegel's speculum in order to adequately remove the tenacious mucoid secretion, many strands of which will stretch out from the ear some three inches before "giving way."

Recurrent ear pain and/or deafness is a must indication for adenoidectomy or tonsillectomy and adenoidectomy. Samuels¹¹ pointed out that poor results on hearing improvement are often found when a T & A has been done, without an accompanying myringotomy. Most often an immediate pronounced change is noted by the child following myringotomy. He awakens complaining that the normal ambivalent sound is too loud and "hurts." He rarely has any postoperative ear pain. The drums heal in a matter of four to seven days.

Many allergists feel that obstructing or infected tonsils and adenoids should be removed before instituting allergy therapy, and often the pediatrician has noted that a typically "allergic" child loses his symptoms following removal of adenoids and/or tonsils.

In 1954, during the winter months, myringotomies were carried out on thirty three patients, all but four of them were bilateral. They ranged in age from six months to eleven years, their histories ranged from six bouts of fever and ear pain in four months, to increasing occurrence and longer lasting deafness for a period of two to eight years. In nearly all the cases, the patients had received adequate amounts and duration of one or several antibiotics, to which they responded temporarily. All of these patients able to be tested had negative Rinnes, in addition to full drums, either white or tawny. Five patients had had a previous tonsillectomy or adenoidectomy or radium. Very few had had discharging ears, and none had ever had a myringotomy.

Treatment consisted of myringotomy and aspiration of the serous exudate in every case, and was usually accompanied by primary or secondary adenoidectomy or tonsillectomy when indicated. All cultures were sterile except for a rare pneumococcus.

In a short two year follow-up, only three patients have had any recurrence of ear pain or deafness. In these the symptoms were milder, less frequent, of shorter duration, and responded either to no treatment or to simple nose drops.

Perhaps the most satisfying result was achieved

in an eleven-year-old girl who had had frequent otitis and otalgia since the age of three years, and for the past four years had become increasingly and constantly deaf with a loss of 30 to 50 decibels in each ear. She had had a T & A and radium treatment, and a long series of allergy treatments carried out by competent otologists, but had not had a myringotomy. Her initial response was excellent. However, she required two subsequent myringotomies within six months, and now, for the past year and a half, she has maintained a normal audiogram.

Our problem in carrying out a necessary myringotomy is overcoming the fear and reluctance of parents that the child will have a permanent "perforated eardrum," or that the child will have his hearing further destroyed by the procedure. But fortunately, as the pediatrician, the parent, and the child are becoming more aware of the problem and the simplicity of treatment, less children will be faced with a permanent hearing loss in adulthood.

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EFFORT THROMBOSIS OF THE AXILLARY AND SUBCLAVIAN VEINS

Case Report and Review of the Literature

ROBERT C. RAINIE, M.D., *Concord, New Hampshire*

THE syndrome of idiopathic thrombosis of the axillary and subclavian veins (Paget-Schroetter's syndrome) has received increasing attention during the past twenty years. The original description in 1875 was documented by Sir James Paget under the title "Gouty Phlebitis."¹¹ In 1884 von Schroetter¹² reported its occurrence in the right arm of an otherwise healthy painter. Although this clinical entity stimulated a great deal of foreign literature during the ensuing years, it was first reported in America by Wilson¹⁵ in 1922 and by Lowenstein⁷ in 1924. However it was Matas⁹ in 1934 who recorded the classic account of axillary vein thrombosis. The original descriptions restricted the syndrome to venous obstruction in the upper extremity of the apparently healthy person, but Crane² has emphasized that it may occur in the lower limbs also. An excellent report by Hughes⁴ in 1948 reviewed 320 cases, and in 1949 Kleinsasser⁶ discussed his 16 personal cases describing the various types of effort which may precipitate this syndrome. Unfortunately many of the reports on thrombosis of the axillary and subclavian veins do not segregate the spontaneous from the traumatic types.¹⁴ The following case is reported as a typical example of this syndrome.

CASE REPORT

E. L., a 33 year old, white, right-handed male, was admitted to the Concord Hospital, Concord, New Hampshire, on June 16, 1952 with a chief complaint of swelling and discoloration of the right arm of five hours duration. History revealed that three days before entry he had lifted three heavy cases while at work. Two days before entry he helped move a refrigerator across a room using primarily his right arm and shoulder to obtain leverage. On the morning of admission he awoke with pain in his right shoulder and along the inner aspect of his right arm. During the morning he noted that the right arm appeared larger than the left and also seemed discolored. When it began to ache he became alarmed and was seen at the office and sent to the hospital with a presumptive diagnosis of effort thrombosis. The remainder of his history was non-contributory except that he had normal chest x-rays in 1951 and 1952.

The Author. *Internist, Staff Physician, Concord Hospital, Concord, New Hampshire*

SUMMARY

A case report of spontaneous idiopathic thrombosis of the axillary and subclavian veins with complete recovery is presented. A review of the literature reveals that the exact etiology of this syndrome is still obscure. Minor effort and strain are frequent precursors, while some authors favor sympathetic venous spasm with slowing of the blood stream and others feel it is due primarily to compression of these veins by the adjacent muscle or skeleton during unusual exertion of the extremity. The clinical picture is that of pain, cyanotic discoloration, and venous distension of the affected limb. Therapy consists of elevation and immobilization of the arm in warm, moist compresses. Pulmonary embolism probably occurs more frequently than has been suspected, and therefore anticoagulants should be used routinely. Cervical sympathetic block reduces edema and vasospasm. Surgery has been performed in some persistent cases. Although most patients have received some form of therapy, it should be emphasized that the natural course of the disease is that of spontaneous recovery.

Physical examination revealed a well developed white male in no acute distress. Temperature, pulse and respirations were normal and the blood pressure was 120/80 in both arms. The pertinent findings were restricted to the right arm and chest. There was no cervical adenopathy or venous distension. Over the right upper anterior chest there was a definite increase in the superficial venous pattern as compared to the left, but no tenderness. The right arm showed diffuse cyanotic discoloration distal to a line of demarcation at the midportion of the deltoid muscle. The right forearm was one cm. larger than the left and the right arm was one and one-half cm. larger than the left. There was pronounced distension and engorgement of the veins over the entire right arm. No tenderness or structural abnor-

mality was noted on palpation of the veins in the arm and axilla.

Laboratory data revealed a normal hemogram with a normal differential. Platelets appeared normal. Sedimentation rate was 14 mm./hr., clotting time six minutes, prothrombin time 90 percent of mean normal, urinalysis normal and Hinton negative. Subsequent prothrombin times were kept within the therapeutic range of 10 to 30 percent of the mean normal. A venogram of the right arm was reported as follows: The median basilic vein was injected with Neo-Iopax and stereo films of the axillary region were obtained; the axillary vein was obstructed in the lower half of the axillary region, and the distal segment of the vein was moderately dilated; a progressive filling of the collateral venous channels in the region was evident on serial study.

The course of this patient during his seven day stay in the hospital was uneventful. He remained afebrile and complained of only a mild arm ache which was considerably aggravated by a local reaction after the venogram. The entire right arm was elevated and encased in hot moist compresses constantly. Anticoagulant therapy was carried out in the accepted manner with the prothrombin levels being kept within the therapeutic range with Dicoumarol. Right stellate ganglion sympathetic blocks were performed on June 16 and 17 with resulting Horner's syndrome but without obvious effect on the extremity. On June 19 venous pressure in the right antecubital vein was found to be 42.0 cm. and in the left 9.4 cm. The effect of exercise was not demonstrated. On June 20 a venogram revealed definite obstruction in the axillary vein. Following this procedure local erythema, edema and tenderness appeared at the site of injection and along the course of the median basilic vein. This phlebitis gradually subsided leaving a completely thrombosed vein. Venous pressure studies were repeated on June 24 with a reading of 30.0 cm. in the right arm and 9.6 cm. in the left. Unfortunately infra-red film was not available to demonstrate the venous pattern over the chest wall. At no time could a tender thrombosed axillary vein be detected clinically.

Following his discharge from the hospital on June 24, 1952 this patient was seen frequently. There was a gradual decrease in venous engorgement and distension from an original circumference measurement which showed the right upper extremity to be 1.5 cm. larger than the left to a recent measurement revealing only 0.5 cm. difference. This latter figure we have found to be the average difference in upper extremities in a group of normal right-handed males. The discoloration slowly disappeared except when increased activity in the early stages produced mild cyanosis, and even this has not occurred during the past year in spite of very vigorous activity. Venous pressures were performed on October 6, 1952 and again on July 19, 1955 with approximately the same findings, namely, 18.0 cm. on the right and 11.0 cm. on the left.

At the present time this patient demonstrates a complete recovery. He engages in all strenuous activities without discomfort or change in appearance in the arm. The venous pattern over the right upper anterior chest is no longer prominent. The veins over the lateral aspect of the extremity

are more distended than those over the medial area. The originally involved veins can be felt as a small fibrous band.

DISCUSSION

Although the syndrome of effort thrombosis of the veins of the upper extremity has aroused considerable attention in the literature, there is little unanimity of opinion regarding its etiology and pathogenesis. Various reports^{7,14} have implicated compression of these veins by adjacent muscle or skeleton during unusual exertion or motion of the extremity. Such anatomical structures as the pectoralis minor, the coracoid ligament, the subclavius muscle, the head of the humerus, the clavicle, and the first rib have been thought to be involved. This has resulted in the description of the "cervical rib syndrome," the "costo-cervical compression syndrome," the "hyperabduction syndrome," and the "malposition syndrome."

The other principal hypothesis has been that of sympathetic venous spasm with slowing of the blood flow. Martino⁸ adheres to the neurogenic theory that irritation of the sympathetic nerves causes a segmental spasm of the vessel. He concludes that effort alone will not cause any laceration of the intima of the vessel, but that by its continuous irritation of the vasal sympathetics will cause venous spasm which will predispose to thrombosis.

Crane² suggests increased pressure in the veins, muscular contraction of the limb and peripheral venous engorgement as precursors to spontaneous thrombosis of the lower extremity.

Other causative factors suggested have been venous stasis, abnormality of the intima of the vein, nonspecific infection, and minor trauma, but none of these has been consistently present. In spite of the fact that minor effort or strain seems to be a frequent precursor, the actual pathogenesis of this syndrome remains as obscure today as it was over half a century ago.

Although the age range is great, most cases occur in the second and third decades. Males are afflicted three times as frequently as females, with the right arm being involved twice as often as the left.

The clinical characteristics of this syndrome are variable. The mode of onset may be sudden with severe pain, usually at the site of thrombosis, or gradual with asymptomatic enlargement of the affected extremity. This swelling involves the entire arm and sometimes the chest wall and is due primarily to distended veins, with increased interstitial

fluid playing a less important role. The arm assumes a cyanotic discoloration which is more evident in the dependent position. Veins over the entire arm become greatly engorged and distended, and previously unnoticed collateral veins over the neck and chest may become apparent. Paresthesias may be present, and Wilson¹⁵ has reported transient paralysis of the affected arm. Motion may be limited by pain and swelling. Palpation of the axilla may reveal a cordlike structure and tenderness or may be entirely negative. Venous pressure is usually elevated, and there is an exaggerated rise following exercise. Venography is a great aid in localizing the thrombosis and determining the adequacy of collateral circulation. However, this procedure is not without undesirable side effects in some patients. Infra-red photography may demonstrate the engorged, dilated superficial veins.

An evaluation of therapy of this syndrome is difficult since recovery may occur rapidly without residual, or it may be prolonged with persistent trouble. Although some patients receive no treatment, others have been subjected to radical surgery such as removal of the thrombus, resection of the segment of involved veins, scalenectomy, or simple exploration.

Most authors agree that the patient should be placed at bedrest with the arm elevated and immobilized in warm, moist compresses. Some believe that active motion is indicated from the onset to stimulate the development of collateral circulation.

Earlier reports^{14,6} stressed the fact that pulmonary embolism practically never occurred. It was thought that the thrombosis establishes itself in its entirety at once, does not progress, and does not throw off emboli, thus making it unnecessary to use anticoagulants. Hughes⁴ in a very extensive review of 320 cases states that nonfatal pulmonary embolism "is of extraordinarily rare occurrence, if indeed it ever occurs." However, in 1951 Barnett and Levitt¹ reported the first case of pulmonary embolism in idiopathic thrombosis of the axillary vein with good response to anticoagulant therapy. Tomlin¹³ discusses this complication and feels that its incidence is much greater than has been suspected, stressing the frequency of other underlying disease, such as cancer, congestive failure, and local trauma. Because of the thrombotic nature of the syndrome, heparin and Dicoumarol are being used almost routinely

to prevent local propagation of the thrombus and aid in the establishment of collateral circulation.

Cervical sympathetic block has recognized value in spite of its short effect. It reduces edema and vasospasm and may be helpful at any time during the course and certainly should be given a trial before any surgery is performed.

There is a high incidence of recurrences and relapse in those patients who attempt excessive activity too early in the period of convalescence. Rehabilitation should therefore be done gradually and with caution.

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THE VERSATILE RESECTOSCOPE

WALTER A. SCHLOSS, M.D., *Hartford*

TRANSURETHRAL resection of the prostate, or T.U.R. as it is usually called, is a procedure well known to all physicians, surgeons and urologists. What is not so generally appreciated is the varied uses which can be made of this versatile instrument.

Some of these uses have been succinctly stated by Dr. Leonard Murphy of Melbourne, Australia, in the *Medical Journal of Australia*¹ in 1954. Briefly summarized, Murphy's paper mentions the following conditions other than prostatism for the use of the resectoscope:

1. Bladder neck obstruction in the female.
2. Bladder neck obstruction in children.
3. Bladder neck obstruction following operation on the rectum.
4. Neurogenic bladder.
5. Bladder tumors (for biopsy and for therapy).
6. Ureterocoele.
7. Opening prostatic abscesses via the urethra.
8. Evacuation of blood clots, pieces of calculus, and large resection pieces that fail to come out with the evacuator.
9. Resection or incision of the neck of a bladder diverticulum—"diverticulotomy."

The following case reports illustrate other uses for this multipurpose instrument.

CASE REPORTS

1. REMOVAL OF FOREIGN BODY (THERMOMETER) FROM BLADDER²

A 29 year old, white female was taking her temperature vaginally every morning per instructions of a gynecologist in another city in an effort to determine ovulation time. One morning the thermometer disappeared and she could not find it. Vaginal and rectal examination failed to disclose the thermometer. A diagnosis of foreign body in the urinary bladder was suspected, and soon confirmed in the office by observation cystoscopy without anesthesia. The thermometer was seen lying transversely in the bladder. The patient was immediately hospitalized and that afternoon the thermometer was removed from the bladder in one piece using the resectoscope.

Technique: First, several attempts were made to guide the end of the thermometer into the sheath of a 28F McCarthy foroblique panendoscope with the foreign body

The Author. Assistant Visiting Urologist, McCook Memorial Hospital, Hartford; Associate Urologist, Mt. Sinai Hospital, Hartford; Attending Urologist, V.A. Hospital, Newington, Connecticut.

SUMMARY

The use of the resectoscope is described to extract a thermometer from the bladder, a broken piece of nephrostomy tube from the renal pelvis via a nephrostomy sinus, two large calculi from the lowermost right ureter, and a broken catheter tip from the intramural portion of the ureter.

grasping forceps. This was unsuccessful, but the thermometer was turned so that instead of lying transversely in the bladder, it pointed toward the internal urethral opening. Dr. D. Dillon Reidy, attending urologist at St. Francis Hospital, suggested the use of the 28F Stern-McCarthy resectoscope. The tip of the thermometer was guided into the electrotome loop and thus into the resectoscope opening by numerous excursions of the electrotome loop and manipulation of the resectoscope (Figure 1). When the tip of the thermometer was inside the electrotome loop, pointing straight into the urethra, the entire instrument was withdrawn as pressure was made on the bladder suprapubically

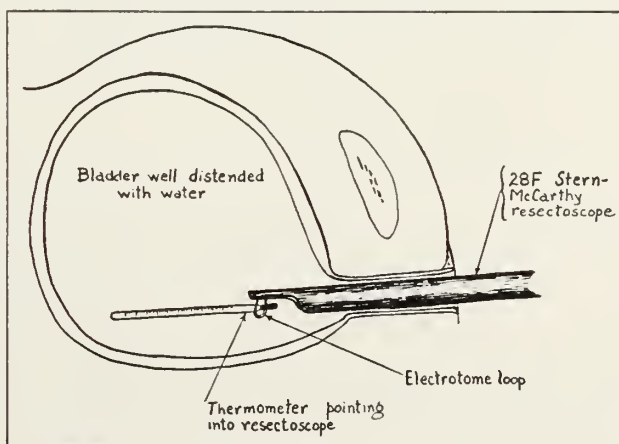


FIGURE 1

Diagrammatic representation of the technic used in removing thermometer from the bladder with resectoscope

by an assistant. The thermometer came out intact, still within the loop, with its tip inside the resectoscope sheath.

The patient was able to go home the following day, with only slight dysuria.

COMMENT

Rectal or oral temperatures are just as accurate as vaginal temperatures for determining ovulation time, and much safer. The use of the resectoscope avoided open surgical intervention in this case, as well as obviating the danger of using a grasping or crushing instrument in removing a glass object from the bladder.

2. REMOVAL OF FOREIGN BODY FROM RENAL PELVIS³

A 41 year old, white male had had a right nephrectomy and left nephrostomy for urinary tuberculosis over the course of several years. The left nephrostomy had been

nephrostomy sinus had been dilated by the endoscopic procedures.

Blood replacement was given, as the hematocrit was low, and antibiotics were started prophylactically. Since the urine was strongly alkaline, the catheter was irrigated with one per cent phosphoric acid solution.

When his condition stabilized and the nephrostomy tube drainage remained clear for 72 hours, he was taken to the operating room. With the use of a high spinal anesthesia the renal pelvis was visually explored with the 24F panendoscope via the nephrostomy sinus. The foreign body was seen but could not be grasped with the alligator or biopsy forceps because it kept moving away in the capacious renal pelvis. The visualizing lithotrite was next tried, but this too was unsuccessful since the piece of catheter could not be grasped in the jaws of this instrument. It kept slipping away. Aspiration with the Ellik evacuator was also tried via the panendoscope, but was unsuccessful, and in addition caused the patient considerable pain, probably from overdistention of the pelvis and calices.

Because of a previous success in removing a foreign body (thermometer) from the urinary bladder with the resectoscope, this procedure was employed. The nephrostomy tract was dilated to 28F with straight sounds. The Nesbit resectoscope 28F was then introduced without difficulty, and with surprising ease the piece of nephrostomy tube was

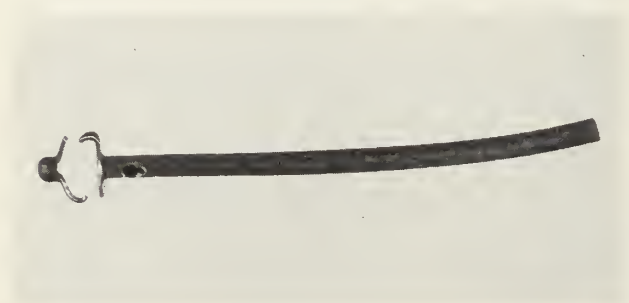


FIGURE 2

Photograph showing where break occurred in head of two-wing Malecot catheter, tip of which remained in renal pelvis

done three years prior to the present episode and he had had periodic changes of the nephrostomy tube since then.

He came to the Veterans Administration Hospital in Newington, Connecticut, with the following story: The previous tube, a two wing Malecot, had fallen out and his local physician had inserted a small (18F) straight Robinson catheter. This catheter was in place, but there was considerable leakage around it.

This catheter was removed and a 22F two-winged Malecot was inserted into the nephrostomy with some difficulty by the resident, as the tract had apparently become somewhat stenosed. This catheter did not drain properly, and it was decided to remove it at once and try to reinsert another. When it was pulled out, the distal half of the head of the catheter was missing (Figure 2). No urine escaped from the nephrostomy opening. Several attempts were then made to recover the catheter tip by the use of a Kelly clamp, but each time only a minute fragment of rubber could be recovered. Attempts were then made to grasp the catheter by using the panendoscope and foreign body forceps, but again only minute fragments were recovered. Soon the entire piece disappeared from vision and bleeding became somewhat alarming. A new 22F Malecot was then inserted without too much difficulty, since the

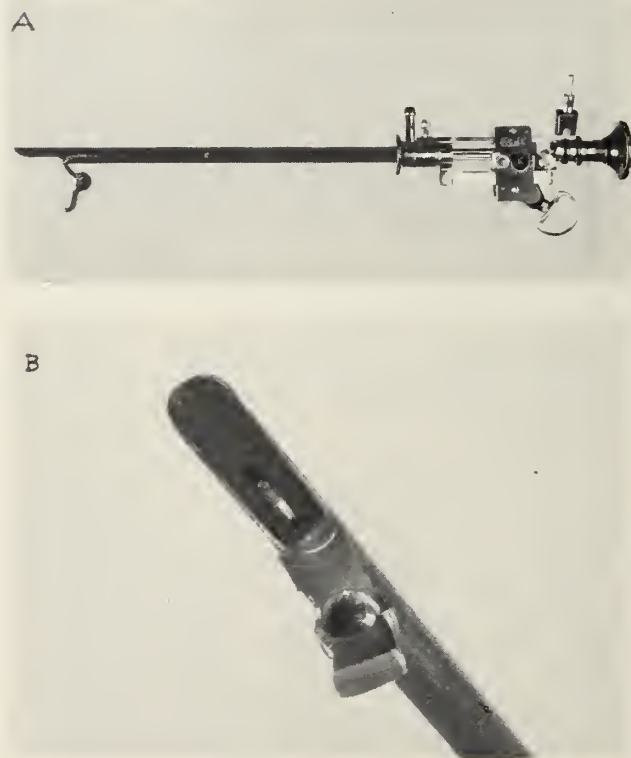


FIGURE 3

A, photograph showing how tip of Malecot catheter was grasped by electrotome loop of Nesbit resectoscope and withdrawn via nephrostomy sinus. B, close-up view of loop engaging catheter tip

caught between the electrotome loop and the resectoscope sheath under perfect vision. The resectoscope was then removed in toto, holding in place the foreign body which came out intact (Figure 3).

A new Malecot nephrostomy tube was readily inserted, and the patient was able to be discharged from the hospital 48 hours later.

COMMENT

The resectoscope made it possible to remove easily a foreign body (piece of nephrostomy tube) from the renal pelvis via the nephrostomy sinus when all other instruments failed.

3. TWO LARGE CALCULI EXTRACTED FROM LOWERMOST URETER WITH RESECTOSCOPE

A 74 year old, white man had right flank and right lower quadrant pain. A kidney-ureter bladder film showed a calcific density in the right kidney, as well as two large stones in the terminal right ureter. Figure 4 shows a spiral stone dislodger in contact with the lowermost stone, with the second stone just above it, and another stone in the right kidney.

At cystoscopy a large calculus was seen protruding part way out of the right ureteral orifice. Various cystoscopic instruments were used to attempt to dislodge the calculus. All were unsuccessful. The calculus was tightly wedged in the orifice.



FIGURE 4

This film shows a spiral stone dislodger in contact with two large calculi in lowermost right ureter

The resectoscope was used to take one bite out of the roof of the ureter, following which the stone was so loose that it could be teased out of the orifice by wiggling the electrotome loop back and forth over the protruding part of the stone until it finally fell free in the bladder. It would not come out with the Ellik evacuator and was too large to be grasped by the foreign body cystoscopic forceps. Crushing with the lithotrite was not considered desirable. So it was caught between the electrotome loop and resectoscope sheath and the entire instrument was withdrawn, with the stone caught between loop and sheath, just as the piece of rubber tubing was extracted from the renal pelvis.

The second calculus was dragged down to the ureteral orifice by manipulation with the spiral stone dislodger; being too large to fit inside the dislodger (Figure 5) it would not come out into the bladder, but the tip of the stone could now be seen. Again the resectoscope was used to milk the stone out of the ureter by placing the electrotome loop beyond the stone and then pushing on the stone from behind, until it finally came out of the orifice. It too was removed from the bladder by catching it between the electrotome loop and resectoscope sheath and withdrawing the entire instrument.

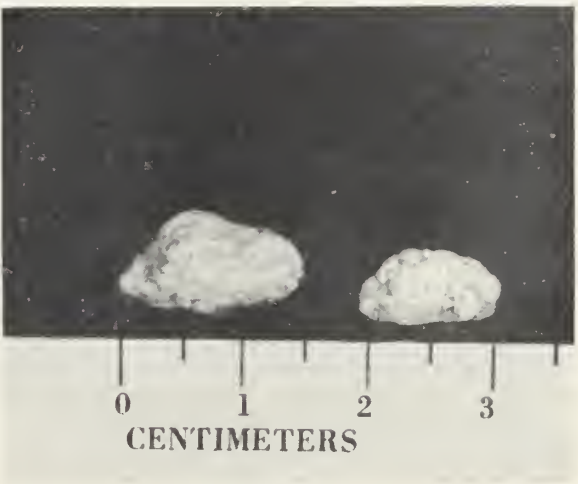


FIGURE 5

Photograph of the two large calculi removed from right ureter with resectoscope

The patient had some abdominal discomfort, nausea and vomiting for two days, and some hematuria, but this cleared up and he was discharged on the fourth hospital day. The caliceal calculus was left undisturbed.

COMMENT

The resectoscope should always be considered as a modality for any calculi that are peeking out of the ureteral orifice or are in the bladder portion of the ureter, wherein the roof of the ureter can be resected, and the stone milked down and wiggled out of the ureter with the electrotome loop.

4. REMOVAL OF BROKEN URETERAL CATHETER TIP IMPACTED IN LOWERMOST URETER

A 59 year old, colored male with dysuria, frequency and hematuria was undergoing routine cysto-urethroscopy with retrograde pyelography, which showed a diverticulum of the bladder and benign overgrowth of the prostate.

The end of the ureteral catheter became looped in the left renal pelvis. On withdrawing the catheter it was immediately apparent that the terminal 2.5 cm. had broken off in the patient (Figure 6). X-ray confirmed this, showing the tip of the catheter folded on itself and impacted in the lowermost left ureter (Figure 7).

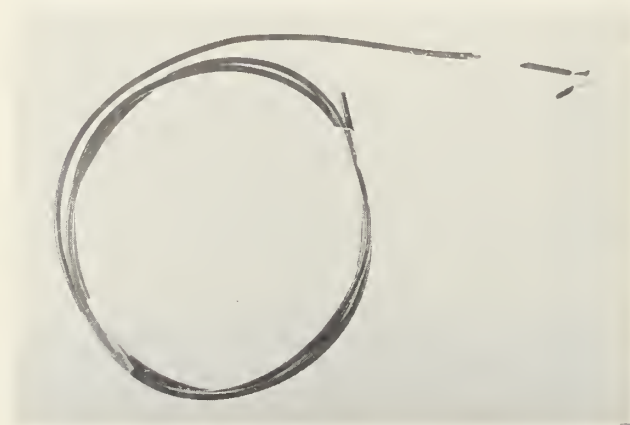


FIGURE 6

Photograph showing where break occurred in 5F ureteral catheter

The cystoscope was then re-introduced, and the broken end of the catheter was seen just peeking out of the left ureteral orifice. Attempts were made to extract the broken catheter with a) the alligator foreign body cystoscopic forceps, b) the clam shell cystoscopic biopsy forceps, c) the spiral stone dislodger, and d) the Johnson stone basket, but all were unsuccessful. These only succeeded in driving the broken catheter tip a little further into the ureter.

Recalling previous successes with the resectoscope, it was decided to resect the roof of the left ureter. Using the 28F Nesbit resectoscope, the roof of the ureter was cautiously resected, exposing more of the broken catheter tip. It was then teased into the bladder by manipulation with the electrotome loop, using no current. By wiggling and teasing, milking and prying, it was the work of only a few minutes before the broken catheter tip was in the bladder. It was then picked up between the loop and the sheath of the resectoscope and extracted from the bladder by withdrawing the entire instrument. X-rays then showed that the catheter tip had been completely removed. The pieces were

matched showing that the missing fragments had been recovered. The patient had no ill effects from the procedure.

COMMENT

The resectoscope was used successfully to extract a broken catheter tip from the lowermost left ureter after other cystoscopic instruments had failed to do so.

CONCLUSION

The resectoscope should always be considered for use in extracting objects from the bladder, or intra-



FIGURE 7

This X-ray shows the broken catheter tip in lowermost left ureter with column of contrast substance trapped above it

mural ureter, or via a nephrostomy sinus from the renal pelvis, or anywhere else it might prove to be useful.

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INJURY, ICE AND COMPRESSION

EFFECTIVE first aid after injury diminishes tissue damage. Splinting for broken bones and occlusive dressings for external bleeding are established. Cold and compression for injury may also have a place in trauma therapy.

Resort to cold applications was necessary after an explosion in a navy vessel with a large number of burn casualties.¹ Plasma and morphine supplies gave out and ice was used for the treatment of burned parts. Greater local comfort and diminished toxic symptoms were observed with the change of treatment, an unexpected result of the improvised method.

Cold therapy has been used experimentally in advanced human cancer,² and cold as an anesthetic for the amputation of gangrenous limbs. For hibernation anesthesia in advanced cardiac surgery it has found a place. Oxygen consumption of cooled guinea pigs is diminished by one half and cold for treatment of neonatal asphyxia is contemplated.³ For athletic injuries the early use of cold compresses is advised. The general use of cold in first aid treatment of burns, fractures and complicated injury may be advisable.

Animal experiments showed that cooling the skin after injury to a temperature of 70 degrees Fahrenheit led to the lowest mortality, 18 per cent. Skin temperature of 85 degrees Fahrenheit gave a 45 per cent mortality and 93 per cent at 95 degrees Fahrenheit. But cooling down to 52 degrees Fahrenheit led to a mortality of 38 per cent. In first aid an estimate of skin temperature should be made before using either blankets, fans, or cold compresses.

When shock has been overcome and damaged tissue removed, there is normally no need to continue cooling since local healing is more satisfactory at body temperature. Cooling of the skin for shock produces vasoconstriction, lowers the metabolism of less important structures, and conserves circulation blood for use by the vital centers. Rectal temperature readings usually remain normal in mild shock; but, if the rectal temperature falls and is allowed to go below 90 degrees, coma ensues (which in cancer therapy was the planned result).

SIDNEY VERNON, M.D., *Willimantic*

The Author. *Courtesy Staff, Windham Community Hospital, Willimantic, Connecticut*

SUMMARY

Cold applications in trauma therapy are simple, readily available and useful. Fullest opportunities of cold therapy may be made by incorporating it into standard clinical practice and first aid teaching.

Standard use of cold combined with compression is advantageous in special conditions. A compressive dressing which controls bleeding may be life saving, yet pressure on anemic or devitalized tissue is not safe. Devitalized tissue may incubate bacteria and warmth would accelerate this process. Lower temperature to inhibit bacterial growth in devitalized tissue is more ideal. Ideal level of cooling for localized injury is lower than 70 degrees or room temperature.

Opinion on tourniquet use in first aid varies. Some would avoid tourniquets entirely; but if a tourniquet is used, continuous application rather than intermittent release is better to avoid critical blood loss. Pneumatic tourniquets for a bloodless field in surgery are in standard use. An automatic tourniquet has been devised for emergency use.

Shock may occur after tourniquet release and the use of cold may minimize this ill effect. The danger of release shock is increased by a high tourniquet, prolonged application, too rapid release, extensive damage distal to the tourniquet, and poor condition before release. The application of cold to an injured bleeding extremity to which a tourniquet is applied conserves its vitality as well as protecting the patient from shock after tourniquet release.

FRACTURES

An ankle fracture may be corrected with anatomical reduction if edema and hematoma do not supervene before manipulation. Edema may prevent perfect reposition of fragments. Ice applied after injury even for a short period slows the traumatic

edema response and a compression dressing controls interstitial ooze. With ice and compression, the time taken before manipulation for x-ray study would not jeopardize the quality of the result. Fractures with wide separation of fragments may lead to easy reduction when cold and compression are applied early. Refrigeration has also been used for anesthesia for fracture reduction. The use of cold after plastic reconstruction following injury makes the postoperative course smoother, more painless, and the entire procedure more effective.

BURNS

There is now general agreement that the principal cause of burn shock is the loss of circulating plasma and red cell components into the burn zone. Prevention of burn shock may be aided by slowing down this process. Application of cold to the skin produces local vasoconstriction. Cold retards the flow of lymph and development of edema in the experimentally burned foot. Local treatment with cold beginning earlier than six hours after burn injury influences the ultimate result.

In generalized burns, excessive cold must be avoided since fluid and electrolyte balance problems are more complex. In animal experiment with thermal trauma involving three fourths of the body surface, it was shown that skin temperature of 72 degrees Fahrenheit was optimal for recovery. For extensive burns, fastidious temperature control should be observed.

Accidental radiation injury that occurred in nuclear research was treated by immobilization, irrigation, and cold applications. Cold is unique in inhibiting simultaneously pain, exudation, thrombosis, shock, infection, toxic absorption, and tissue devitalization.

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THE PRICE OF FREE MEDICINE

COLM BROGAN

Britain's experiment in socialized medicine should be of interest to those who wonder if the United States ought to try it

The Author. *British journalist, author, advocate of individualism, and critic of socialism*

LAST year the British National Health Service paid one million pounds (\$2,800,000) for bottles and other containers to be used for drugs and medicine. In contrast, the grant for research in mental health was a mere 27 thousand pounds (\$75,600).

These figures illustrate the most damaging though least heeded effect of socialized medicine. Floods of money feed the insatiable appetite for pills, while fundamental medical research is largely neglected. Intelligent doctors are fully aware of this threat to the whole future of British medicine, but the British people generally do not sense the danger. Socialized medicine allows popular demand to dictate the use of available resources through political pressure, the

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consequence being this gross distortion of the strategy and tactics of medical development.

Not even Mr. Bevan himself denies that the British people are heavily overindulging in nostrums of dubious value. Faith in these nostrums is scarcely more intelligent than faith in magic, but vast sums are poured out of the public purse for cures of largely imaginary value for diseases which are also largely imaginary.

At the same time, nearly half the hospital beds in Britain are occupied by mental patients, and many would-be voluntary patients must be refused admission. Conditions in some of these mental hospitals are deplorable. They are badly understaffed and shockingly overcrowded. Yet not one new mental hospital has been opened in Britain since the start of the Health Service, nearly eight years ago. In fact, no hospital of any kind has been built and opened.

At a time when both medical advance and the challenge to medicine are undergoing great and dramatic changes, British practice is being fossilized in attitudes as out-of-date as the hansom cab and the wooden stethoscope.

That, of course, was not the original purpose of those who framed the Health Act. They offered it as an "experiment noble in purpose;" and the British people were promised everything, regardless of expense. Not only would their home treatments be provided free of direct charge, but the hospitals would for the first time have ample funds for treatment and research. It was said to be a disgrace to a progressive country that the great voluntary hospitals, some of them of worldwide fame, should be dependent on uncertain charity and sorely handicapped in their beneficent work. There would no longer be any need for humiliating appeals, nor restrictions on staffing, building, or research; and in addition, health centers would be established everywhere to bring all the general practitioners of an area together in happy comradeship, with all the most expensive resources of modern medicine at their immediate command.

That was the fine dream, but the reality proved to be far different. The administrators soon found themselves faced with two inescapable facts. The available supply of trained doctors, nurses, medical scientists, and members of the semiprofessional ancillaries like physiotherapists and orthopedists was not enough to meet all the needs of the grandiose plan. The financing of the plan was even more strictly limited. Enthusiasts for nationalized medi-

cine found themselves in competition with the enthusiasts for extended education, state subsidized housing, higher state pensions and benefits, and a dozen other schemes with a strong emotional and vote-catching appeal. There was competition not only for funds, but also for materials and for future staff. While hospital wards were shut for lack of nurses, the potential nurses of the future were tempted into teaching to meet the demands of the risen birth rate and the extra compulsory year at school ordained by the socialist government. Building materials and labor that might have been used for temporary hospital and clinic accommodations were used for temporary classrooms.

If no checks had been put on Health Service expenditure, it would have assumed fantastic proportions. But when expenses soon came to more than double the original estimate, it was found necessary even for a socialistic government to impose a ceiling and eventually call a halt.

A part of the corrective action attracted much attention and stirred a good deal of resentment. The patient looking for spectacles or for dental treatment had to pay a proportion of the cost, and for some the proportion was substantial. In addition, all patients were required to pay a shilling for each prescription filled. The prescription charge failed in its purpose, however. Most of the patients resented having to pay and tried to get as much as possible on one prescription, which doubtless encouraged waste. In any event, the Labor Party, which originally imposed the charges, promises to abolish them when they get back to office—a measure of the depths to which demagoguery can sink.

But the other thing that was done attracted little notice outside of the medical profession. Dentists were paid by piecework, and the original rates for the various jobs were lavishly set to coax dentists into the scheme. For some time, dentists were in financial clover. But the rates have been slashed three times, reducing dentists to a very modest standard and putting some in grim financial difficulty as they must pay surtax on the high earnings of a previous year out of a current income drastically reduced by arbitrary decree. This situation has brought a catastrophically reduced enrollment in dental colleges, thus ending most dreams of a dental service that would concentrate on scientific conservation instead of hasty pulling and patching.

The doctors fared better than the dentists. Their resistance to the scheme had been so strong that

they were offered an income equal in purchasing power to the average medical income of 1938. When R. A. Butler became Tory Chancellor of the Exchequer, he was faced with an arbitration award which gave general practitioners not only an increased annual payment for each patient but also a lump sum of fifty million pounds to make up for past underpayment. Nurses and lay hospital workers were in no mood for cuts in salaries and wages. Inflation steadily increased the bill for all hospital supplies and also for the drugs and pills doled out so lavishly through the doctors' offices.

Thus, the National Health Service budget was strained to the breaking point. And the cuts fell on the unprotected sector of health expenditure, though this was the sector which alone could keep Britain abreast of the civilized world in medical advance. The grandiose schemes of expansion were almost all dropped, and the great teaching and research hospitals suddenly found themselves more pinched than they had ever been before. One hospital, which had almost completed an ambitious and modern laboratory, had to turn the key in the lock for a considerable time because they lacked funds for the microscopes needed if the laboratory were to serve its purpose.

This is only one example of a deleterious process. Public demand and demagogic compliance have diverted available funds away from the fruitful and imperative lines of medical advance in order to supply that kind of medicine which satisfies the credulous patient. The mass of the public were well enough pleased. Hypochondriacs and people with nothing much to do could still crowd a harassed doctor's office at no immediate cost to themselves and call for a pill or a bottle which they might have seen advertised. Many doctors have told me that since the enactment of the Health Act a growing number of patients come to the office and say they want this drug or that, not waiting for the doctor's examination and verdict, but making their own selection as they might choose sweets in a confectioner's shop.

There is the case of a woman whose baby was suffering diaper rash. She got a doctor's prescription for no fewer than ten bottles of an expensive new medicament. The rash finally was cured when the woman was told to keep her baby dry and to apply a simple ointment. The ointment which did the trick cost fourpence (about 5 cents); the ten bottles which did no good cost thirty pounds (\$84). This

is one example of waste, but it could be multiplied indefinitely.

The Ministry of Health has tried to deter doctors from easily prescribing expensive proprietary drugs when much cheaper equivalents are available, but the doctors resent any dictation and the patients are even more resentful.

For a long time it has been the ambition of conscientious practitioners to wean their patients away from the pathetic faith in bottles and pills; but the Health Service has undone all such effort, and fundamental medical research is the chief sufferer.

The brilliant triumphs of modern medicine have nearly all been won in the laboratory, not at the patient's bedside or in the doctor's office. The weight of medical investment should be in that direction, but in Britain it is being swung in what is strictly the reactionary and obsolete way.

As for mental illness which is the greatest and most disturbing challenge to Western civilization, the treatment and the cure of this menace is only in its infancy. Patient research and investigation covering the whole of social life are necessary, and equally necessary is a huge expenditure to provide the material means of effective treatment here and now. But there are British mental hospitals where the patients' beds are so crowded that it is impossible even to put a locker between them. It is impossible to get anything like enough native-trained nurses, men and women, for any kind of hospital; but at the same time, many experienced and highly qualified nurses are employed in "welfare" work where their skill and knowledge are thrown away.

I have no space to deal with the wastefully expensive tests and treatments to safeguard the doctors against legal action by litigious patients, whose court action is likely to be paid for by the same State that pays for the hospitals.

I believe that the contemporary and scientific conception of medicine cannot flourish fully and firmly where medicine has been socialized. The great medical advance will continue, but there is nothing in prevailing British conditions to encourage the hope that British medicine will play in the future as remarkable and as leading a part in that advance as it has played in the past. This pessimism is not purely personal. It is shared by nearly every doctor I know who is alive to what is going on in international medicine, while stagnation of method is forced upon himself.

TENTH ANNUAL CONNECTICUT CANCER CONFERENCE FOR PHYSICIANS

Wednesday, March 13, 1957

Hotel Statler, Hartford, 12:45 to 4:30 P. M.

PROGRAM

Presiding: Bernard F. Mann, Jr., M.D.

Associate Pathologist, Hospital of St. Raphael, New Haven, Program Chairman

12:45 REGISTRATION

1:00 A CHALLENGE FOR 1957

Edward J. Ottenheimer, M.D., *President, American Cancer Society, Connecticut Division*

1:10 INTRA-ORAL AND PHARYNGEAL NEOPLASMS—A SYMPOSIUM

Moderator: Colonel James E. Ash, M.D., *U. S. Army Medical Corps, Retired, Washington, D. C.; former Scientific Director of the American Registry of Pathology and Armed Forces Institute of Pathology; Pathologist, Suburban Hospital Association, Bethesda, Maryland*

CLINICAL BACKGROUND AND DIAGNOSTIC ASPECTS

Henry P. Royster, M.D., *Associate Professor of Surgery, University of Pennsylvania School of Medicine; Consultant Plastic Surgeon, Philadelphia*

PATHOLOGIC CONSIDERATIONS

Colonel James E. Ash, M.D.

ROLE OF RADIATION THERAPY

Gilbert H. Fletcher, M.D., *Chief, Department of Radiology, University of Texas; Director of Radiation Therapy, M. D. Anderson Hospital and Tumor Institute, Houston, Texas*

ROLE OF SURGERY

Grant E. Ward, M.D., *Associate Professor of Surgery and Surgeon in charge of Tumor Clinic, Johns Hopkins University School of Medicine, Baltimore*

2:30 INTERMISSION

3:00 CONTINUATION OF SYMPOSIUM

3:40 OPEN FORUM

Written questions are invited. Question cards may be obtained at the registration desk

4:20 CONCLUDING SUMMARY

Colonel James E. Ash, M.D.

4:30 ADJOURNMENT

Postgraduate Credit: Members of the Academy of General Practice may receive postgraduate credit for attending this conference

Sponsored by: CONNECTICUT STATE MEDICAL SOCIETY

CONNECTICUT DIVISION, AMERICAN CANCER SOCIETY

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CONNECTICUT STATE DEPARTMENT OF HEALTH

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EDITORIALS

A Fading Dream

The JOURNAL is privileged to republish in this issue "The Price of Free Medicine," a discussion of Britain's experiment in socialized medicine, which first appeared in *The Freeman* for June. The author, Mr. Colm Brogan, is a British journalist, author and advocate of individualism. He handles his subject with candor and objectivity and it should be of interest to anyone who wonders if a National Health Service after the British pattern would be a good thing in this country.

We have had the opportunity to view the medical scheme in England twice, one after it had been in operation for a year and again after five years, and have talked with many physicians in that country. There was great misgiving at the beginning but on the second visit, changes had been made and some doctors had adjusted themselves to it all. This did not mean that the whole affair was satisfactory but more probably they were making the best of it.

During the last year or two there has been a small but steady flow of young British physicians to this country and in many discussions with them, their answer to the question as to why they wish to migrate has invariably been that the future of medical practice in England is not attractive under the socialized plan.

The British mind has a kind of built-in integrity and expresses itself with ruthless honesty whether it be in the Parliament or at Hyde Park Corner and these young people mean what they say. They would rather take a chance in a new country where

medical practice is still a matter of dignified individual achievement than be regimented into mediocrity. They have said other things, several of which are elaborated in Mr. Brogan's article and, while it should not be concluded that the scheme is a failure, it is far from a success, both from the standpoint of the national economy and the satisfaction of the medical profession.

America should continue to watch this changed pattern of medical service with the utmost interest, for the New Deal and what it stood for is not dead, its specific proposals for socialized medicine are only temporarily absent from the Congress, they will be back with us again.

The Medicare Program

The Dependents' Medical Care Act (MEDICARE) went into effect on December 7. It represents a unique project of the first magnitude in the field of health care coverage. No one can fully appreciate the vast amount of effort contributed to the development and formulation of this program. But this much has been said in all sincerity . . . "Local medical societies, the profession, and the American Medical Association deserve commendation for the contribution they have made in working out a program which will benefit millions of servicemen's dependents and hence the nation." Medical organizations and individual physicians in all parts of the country have, by their efforts in supporting this project, demonstrated a capacity to render a public service of immense value and proportion.

Although the selection of local administrative machinery for this program was a choice left entirely to state medical societies, it has been gratifying to note that Blue Shield plans have almost universally been chosen by their medical societies to provide administration for MEDICARE. This is evidence of the confidence the profession in each area has in its Blue Shield plan like Connecticut Medical Service and should go a long way in establishing Blue Shield as an administrative organization if and when other government plans for providing medical services come into operation.

A Word on the Doctor's Library

Today books and medical periodicals are readily available to the doctor from large medical libraries, yet most physicians maintain a reference or working library for convenience. As books and journals become obsolescent, limitation of storage space may bring up the problem of their disposal. Books no longer of use are often sent to hospital, medical society, or medical school libraries to be added to these collections or to be used for interlibrary exchange. The value of journals to the larger medical libraries sometimes is not realized and too often these find their way into waste paper disposal. The value of journals in special medical fields is particularly high, especially when they represent runs over a period of years. It often happens that in the settling of a doctor's estate books are retained and journals cast aside. Every medical librarian knows of instances of this kind which to him represent tragedy.

The appeal to doctors here is that before discarding books or unwanted medical journals call or write to the librarian of one of the larger medical libraries. His divining rod may find treasure unsuspected by anyone else.

The Medical Significance of Fall-Out From Nuclear Weapons

The question of the possible medical import of so-called "fall-out" from the testing of nuclear weapons is an important one. The more powerful atomic weapons are tested in areas far removed from civilization because the amount of fall-out is known

to be of serious import both in its immediate effects and in remote ones on genetics. In the recent election the testing of atomic weapons was made a major issue and the resulting discussion clearly showed widely divergent opinions on the part of scientists presumably experts on atomic radiation.* Their views related not to the large local amount of fall-out resulting from testing powerful atomic weapons, but to the small quantities which can be detected at points far distant from the test area. Some authorities regard the small amounts as negligible, while others consider them to be potential hazards particularly to succeeding generations. Such differences of opinion clearly indicate the necessity for further study of the whole subject, particularly as any guarantees to entirely stop testing made by Communist governments would be valueless.

G. B.

Advice to Contributors

If you've got a thought that's happy—
Boil it down.

Make it short and crisp and snappy—
Boil it down.

When your brain its coin has minted,
Down the page your pen has sprinted,
If you want your effort printed,
Boil it down.

Take out every surplus letter—
Boil it down.

Fewer syllables the better—
Boil it down.

Make your meaning plain—express it,
So we'll know—not merely guess it,
Then, my friend, e'er you address it,
Boil it down.

Skim it well—then skim the skimmings—
Boil it down.

Can it do without the trimmings?
Boil it down.

When you're sure 'twould be a sin to
Cut another sentence in two,
Send it on—and we'll begin to
Boil it down.

*Science, Vol. 124, No. 3228, pp. 917 and 925, 1956.

PROGRESS IN CLINICAL MEDICINE

DISSOLVING BLOOD CLOTS

MICHAEL HUME, M.D. and WILLIAM W. L. GLENN, M.D., *New Haven*

INVESTIGATION of methods for dissolving blood clots with fibrinolytic enzymes has progressed in recent years to the point at which several agents have received extensive laboratory and some clinical trial. A look at this work reveals that for the present, enough has been accomplished to indicate the desirable qualities which an ideal clot-lysing agent should have. Quite careful evaluation of several approaches to this problem has been carried out, based on an enormous effort on the part of many investigators in the basic problems of the clotting mechanism. These approaches will be considered in turn, and as much as clinical trial has demonstrated their usefulness, an evaluation of the merits of each will be presented.

Interest in rapid dissolution of blood clots followed the early observation that in certain situations characterized by shock, and often following accidental death, the blood soon became incoagulable, and previously formed clots would liquify. It was shown that such blood did not contain fibrinogen, and could not be clotted by adding more thrombin. Thus it appeared to have been altered by the irreversible destruction or digestion of fibrin. Dastre¹ first used the term fibrinolysis, and found that the condition could be induced in dogs subjected to hemorrhage. It was also recognized that chloroform-treated serum became fibrinolytic. When it was shown that normal blood could inhibit the fibrinolytic activity of chloroform-treated serum, it was concluded that the action of chloroform was to inactivate a normally occurring anti-fibrinolysin. Fractionation and simple dilution techniques were found to activate the fibrinolytic system in certain situations, and in 1933 it was demonstrated that filtrates of group A streptococcus culture were fibrinolytic.² In 1941 Milstone reported³ that the fibrinolytic action of streptococcal filtrate was due to the presence in human plasma (or crude thrombin

Dr. Hume. *Instructor in Surgery, Yale University School of Medicine*

Dr. Glenn. *Associate Professor of Surgery, Yale University School of Medicine*

SUMMARY

A review of fibrinolysis is presented as background for a discussion of the present status of clot dissolving enzymes. Trypsin has received a wide clinical trial, with varying results. Except in large doses, it lacks definite *in vitro* fibrinolytic activity. Streptokinase, in its present somewhat impure form, is receiving an early clinical trial. A new preparation of plasmin is receiving laboratory evaluation.

or fibrinogen) of a lytic factor which was heat labile at 56 degrees C., was nondialysable, and was distinct from fibrinogen or thrombin in that purification of these fractions abolished its action. He identified this lytic factor as being present in the euglobulin fraction of plasma, that it would occasionally lyse clots slowly in the absence of streptococcal fibrinolysin, and that it would make rabbit clots susceptible to streptolysin. These facts were confirmed by Christensen and Macleod who demonstrated⁴ that chloroform-activated and streptococcal-activated proteases were identical. They postulated that the activation of serum protease by streptococcal fibrinolysin is a catalytic reaction, whereas the treatment of serum with chloroform resulted in removal of serum inhibitor which would allow autocatalytic activation of serum protease. They applied the name "plasmin" to the active fibrinolysin, "plasminogen" to the inactive precursor, and "streptokinase" to the streptococcal activator. The combination of antiplasmin with plasmin is said to be favored by ACTH, cortisone or an extract of

From the Department of Surgery, Yale School of Medicine

Presented at the Fourth Connecticut Cardiovascular Conference, June 8, 1956

spleen.⁵ Some recent work has indicated that antiplasmin may be present in the platelets as well as in plasma.⁶

CHARACTERISTICS OF IDEAL CLOT-DISSOLVING AGENT

It is well, at the beginning, to consider what characteristics would be desirable in a fibrinolytic agent that would be effective and safe for use clinically in dissolving blood clots. It should preferably be specifically fibrinolytic, so that it would digest pathologic fibrin deposits but spare the plasma proteins, such as fibrinogen and accelerator globulin. Digestion of these elements of normal coagulation would tend to render the blood incoagulable, an undesirable complication in any situation, but particularly undesirable in postoperative patients if associated with oozing from a fresh surgical wound. On the other hand, it should not convert prothrombin to thrombin, be actively thromboplastic or promote coagulation by some other mechanism. It should not be so extensively inhibited by plasma that very large doses would be required. It should be nonallergenic and nonanaphylactic, have a medium duration of action and be easily reversible if it became necessary to terminate fibrinolysis. Ideally it should dissolve old and new, soft or adherent, venous and arterial thrombi and emboli.

An examination of how well the agents presently under investigation fulfill these requirements will serve to emphasize the problems that are being met in this field. It is appropriate to mention at the beginning that our evidence clinically for the presence of thrombosis, and for the effectiveness of any therapy, is largely indirect, and that many problems would be simplified were there a direct test that would demonstrate which patient has a tendency to thrombosis, when pathologic fibrin deposits have occurred, and when they have been removed.

THE STANDARD ANTICOAGULENTS

Before considering the proteolytic and fibrinolytic enzymes, it should be mentioned that various reports have implied that clots may be dissolved by the standard anticoagulants, heparin, Dicumarol and Tromexan.⁷⁻¹³ Most of these reports do not postulate the mechanism of this fibrinolysis, although they imply that the anticoagulants are fibrinolytic. Generally they tend to show that a higher proportion of vessels blocked by experimental clots become patent again if the subject is given an anticoagulant than in controls not given anticoagulants. It could be concluded from such evidence that the actual

effect of the anticoagulant is indirect, to prevent further fibrin deposit while other, truly fibrinolytic forces in the subject recanalize the vessel. In at least one instance, however, there is rather striking evidence of fibrinolysis occurring on heparin therapy.¹¹ Thrombi were produced in rabbits by injecting thrombin and thorium-B into the femoral artery. When control animals were compared with heparin-treated animals, it was apparent that much more radioactivity was released into the circulation during heparin treatment than in controls not given heparin. Arteriograms and autopsy in these animals confirmed the effectiveness of clot lysis. The author noted that the first injections of heparin were not immediately associated with a large rise in radioactivity, but that later injections induced large increases, the explanation being offered that as lysis proceeded, it was easier for the drug to be brought into contact with more of the clot.

TRYPSIN AND CHYMOTRYPSIN

Early investigation of the pancreatic enzymes showed that shock could be produced in the dog by the reduction of plasma proteins into peptones and peptides when trypsin was injected rapidly into the circulation. In vitro studies¹⁴ demonstrated that trypsin will convert prothrombin to thrombin and cause clotting if fibrinogen has not been extensively digested as well. Trypsin is certainly not specifically fibrinolytic, attacking fibrinogen at least as rapidly as fibrin.¹⁵

Plasma contains strong inhibitors of trypsin, so that most of it is inactivated in vivo.^{16,17} It has been shown¹⁸ that trypsin will not always lyse clots into which it has been introduced, and Roach and Laufman¹⁹ failed to lyse experimental pulmonary emboli unless trypsin was given prior to clotting. Innerfield, Schwartz and Angrist²⁰ investigated the action of very large doses of trypsin in dogs, did not demonstrate any thrombogenic effect, and observed that shock and the anticoagulant action were both related to dose, being present only if very large concentrations of enzyme were present. They were able to produce clot lysis at dosage levels below which serious systemic effects occurred by regulating the administration of the drug as a slow infusion. Innerfield²¹ reviewed the treatment with trypsin of 428 patients having a wide variety of clinical conditions characterized by intravascular thrombosis or acute inflammation, and concluded that trypsin had a general anti-inflammatory action as well as a specific fibrinolytic effect. Concerning

the thrombogenic effect of trypsin, he postulated that in vitro trypsin can activate thrombin by digestion of prothrombin inhibitor groupings from the prothrombin molecule. It was further suggested that in vivo these inhibitor groupings are quickly replaced in the presence of normal liver function.

Chymotrypsin, another of the pancreatic enzymes, does not activate prothrombin or clot blood¹⁸ but renders the plasma proteolytic. It is extensively inhibited by plasma²² does not activate plasminogen, lengthens the clotting time and does not lyse clotted blood in vitro. It acts to depress the antifibrinolytic activity of plasma.²³ It, too, is inferior to plasmin for dissolving already formed clots.

STREPTOKINASE

The use of streptokinase to activate a fibrinolytic system has had extensive investigation. Commercial streptokinase is a partly purified filtrate of group A streptococcus culture, and contains among other constituents, a desoxyribonuclease and certain inhibitors that modify its action. In its present state of purification it is moderately pyrogenic and hypotensive. These undesirable side effects are apparently due to impurities, inasmuch as adding an excess of specific streptokinase antibody does not abolish them. Streptokinase will activate a lytic system which is associated with a striking fall in plasminogen, a moderate fall in serum inhibitor and fibrinogen and lysis of experimental intravascular clots. In one report²⁴ rethrombosis did not occur if the lytic system was maintained three to four hours longer than was necessary to lyse the clot, but might occur if the drug was stopped sooner. ACTH tended to favor rethrombosis. In humans, streptokinase has been shown²⁵ to cause temperature elevation and a leucocytosis, no change in erythrocytes, hematocrit, coagulation time or bleeding time. During the height of the action of the drug, the site of previous finger punctures tended to bleed. Pyrexia could be controlled with aminopyrine and chlorthimeton. A moderate prolongation of prothrombin time occurred, which may be due to a fall in accelerator globulin.²⁶ Hypotension was constant and significant but if the dose was regulated, shock or syncope could be avoided. Hypotension was not directly correlated with effective clot lysis. Completeness of clot lysis and the speed of lysis varied independently at various dose levels. Fibrinogen, which was slightly depressed during therapy rebounded to higher than normal levels after discontinuing the drug, possibly reflecting increased synthesis. Plas-

minogen and complement were inevitably destroyed.²⁷ The slight fall in fibrinogen and moderate prolongation of prothrombin time paralleled the effectiveness of clot lysis and were dependent upon the degree to which the streptokinase was inhibited. Human subjects given streptokinase were characterized as having a high, moderate or low inhibitor titre according to the lysis time of clots made from their blood when mixed with varying concentrations of streptokinase. The inhibitor was not precisely identified, but was thought to be a combined effect of inhibitor naturally occurring in plasma and inhibitor present in commercial streptokinase. It was heat labile at 56 degrees C., and therefore was distinct from antistreptokinase which develops after streptococcal infection.

PLASMINOGEN AND PLASMIN

Since the purification of human plasminogen by Kline,²⁸ lysis of experimental clots in rabbits and dogs has been accomplished by activating human plasminogen with streptokinase.²⁹ Activated plasmin is more fibrinolytic than fibrinogenolytic, has less general proteolytic effect, and is inhibited to a lesser extent than is trypsin. In doses sufficient to lyse thrombi produced in the femoral vein of dogs by sodium morrhuate, activated plasmin had no anaphylactic or allergenic manifestations, usually prolonged the coagulation time somewhat and was associated with moderate oozing of blood from the fresh wound.³⁰ Oozing ceased when the wound was closed, and the explanation was offered that tissue inhibitors prevented further bleeding. Our experience with the enzyme raises some doubt as to how complete is this local control of wound oozing.

DISCUSSION

From a consideration of the action of these various fibrinolytic enzymes, it can be seen that none in its present form satisfies the requirements for the ideal clot-dissolving agent. Trypsin has been given the widest clinical trial, but the good results that have been reported have not been accomplished by in vitro evidence that the enzyme is anything more than generally proteolytic. Advocates of trypsin claim an anti-inflammatory effect from its use, but others³¹ have observed local pain, tenderness and redness, as well as multiple thrombosis at the site of intravenous infusions. Patients who showed improvement in the signs of phlebothrombosis while on trypsin have been observed to relapse after the drug was stopped, although the therapy had been

continued for seven and a half weeks.³² Streptokinase has received an early clinical appraisal.³³ Thirty patients with thrombophlebitis were described as improved. There was no demonstrable change in the condition of three cases of myocardial infarction. One patient with mesenteric thrombosis recovered. One pulmonary embolus occurred during therapy. It is expected that further purification of streptokinase may eliminate its hypotensive and pyrogenic effects.

Plasmin should qualify as the ideal clot dissolver, because it is a naturally occurring enzyme, is not allergenic or anaphylactic, is not thrombogenic and is inhibited only moderately by plasma. It does cause bleeding from fresh surgical wounds, and tends to prolong the clotting time. Since the method of partial purification of plasmin was published this year by Fishman and Kline of Yale University,³⁴ it will be possible to test the effectiveness of enzymes from which most of the activating streptokinase has been removed. In this laboratory, standard clots made of red cells incubated with radioactive chromate have been introduced into the inferior vena cava of the dog, so as to produce pulmonary embolization. We have been impressed on the one hand by how well this is tolerated by the anesthetized animal and on the other hand by how rapidly the clot is reduced in size and weight by the dog's circulation. In a collaborative effort with Dr. Kline, plasmin, prepared by his method, has been used in an attempt to dissolve these emboli. Various measurements have been made to follow the progress of clot lysis and alterations in the clotting mechanism. A definite wound ooze during the height of the action of the drug, and incoagulability of the blood for four or five hours does occur, but the enzyme has been otherwise well tolerated. However, the amount of lysis has been variable, and this is perhaps because of considerable variation in enzyme inhibitor among the subjects. Clinical application is not planned until consistent results are obtained in the laboratory, and this will be the subject of a more detailed report at a later time.

Thus, of the several approaches to the dissolution of intravascular clots with enzymes, three main areas have received the greatest attention. These are pancreatic trypsin, streptokinase and plasmin. In a fourth area, the anticoagulants have received some consideration, but it is not yet clear that they have a true fibrinolytic action in addition to their better recognized effects. Of the three major enzymes,

trypsin appears too generally proteolytic for systemic use and streptokinase must be further purified to eliminate undesirable side effects. Plasmin has been shown to possess most of the requirements of the ideal clot dissolving agent, but it has only been available in relatively pure form recently, and considerably more experimental and clinical application is necessary before its true value can be appreciated.

The author wishes to thank Dr. J. Haskell Milstone for his advice during the preparation of this paper.

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24 Physicians Get Sears-Roebuck Loans

Assistance in the form of long-term, unsecured loans to 24 physicians for the establishment and improvement of 15 medical practice units has been announced by the Sears-Roebuck Foundation.

These loans, ranging from \$1,000 to \$10,000, were made under the Plan of Financial Assistance of the Foundation and are part of an annual grant to a revolving assistance fund. The loans totaled \$88,500.

The 15 loans just announced go to physicians in Oregon, Washington, southeastern Kentucky, Minnesota, California, Mississippi, Georgia, North and South Carolina, southern Florida, New York, Rhode Island, and a suburban area of New Haven, Connecticut.

The Foundation made the first grant available in 1955. A total of \$261,000 has been granted in 36 loans to 52 physicians in 18 States. Thus far the majority of loans of assistance have gone to two types of physicians: graduating interns just establishing themselves in areas of medical need, and established physicians located in small communities, rural and suburban areas whose medical facilities are so inadequate it is necessary to rebuild in order to provide decent medical care.

Theodore V. Houser, president of the Foundation, also announced that applications are now being received for consideration during the first half of 1957 when approximately \$72,500 will be available for additional loans. Applications received prior to April 1 will be processed no later than June 15. Physicians desiring to apply should have their plans well developed so that proper evaluation may be made. Applications may be obtained from State, county or city medical societies.

The purpose of this plan is to help physicians supplement personal and local financing which is inadequate to cover the entire cost of building, remodeling, equipping, or establishing a medical practice. The Foundation hopes to be of aid in improving medical distribution and medical facilities in areas where there is a shortage of physicians and inadequate facilities exist.

The Foundation administers the plan, while the screening and actual selection of applicants is done by a 17 member advisory board of leading physicians from all sections of the country nominated by the Board of Trustees of the American Medical Association.

THE PRESIDENT'S PAGE

AT the last session of the Congress of the United States, Public Law 539 — the Military Dependents Medical Care Act — was passed. This law became effective December 7, 1956, and put into operation what is said to be the biggest civilian medical care program in United States history. The program is known as Medicare and provides for specified medical services to some two million dependent spouses and children of those in the uniformed services of this country. It is estimated that there are about ten thousand of these dependents in the State of Connecticut.

Congress began developing plans for some such program of medical care for dependents of service personnel in 1953. The first plans provided that medical care would be obtained through the use of military facilities and physicians in the military service. The American Medical Association vigorously opposed these first plans on the basis that they would lead to an extensive federal hospital building program which would require the induction of a greater number of physicians into the armed services and which would lead to an extension of the doctor draft law. The opposition of the AMA was largely responsible for persuading Congress to change its original plans to use military facilities and personnel and to achieve its purpose through the use of civilian hospitals and civilian physicians. The American Medical Association has been the "loyal opposition" from the very beginning and has been instrumental in getting many other, but not all, undesirable features changed or eliminated.

Some sort of a plan to make medical services available to dependents of those in the uniformed services was inevitable and we can be thankful for the alertness of the American Medical Association that the plan is a civilian one and that the medical profession has been largely responsible for fee schedules, even though final authority in all matters rests in Washington.

At the request of the Department of Defense, through the American Medical Association, every State Society, including Connecticut, has signed an agreement with the Department of Defense to act as prime contracting agent and Connecticut Medical Service has been designated the fiscal agent for Connecticut. It should be made clear that CMS is only an agent that pays out Medicare funds as directed according to the rules and regulations in the agreement between the Connecticut State Medical Society and the Department of Defense. Connecticut Medical Service does not insure the Medicare program and it does not determine fee schedules. Fee schedules were recommended by the Medicare Committee of the State Society which was appointed by the Council of the Society. It will be noted that the schedule of allowances, which is a supplement to the February issue of the Journal, is patterned after but not identical with the fee schedule of the CMS preferred contract. The CMS preferred fee schedule would be used as a yardstick by the Medicare committee because nearly all of these people would be eligible for service benefits under CMS preferred contract plan in civil life.

The Department of Defense and the Department of Health, Education and Welfare have proclaimed that Medicare is a service program with full service coverage, although the Act itself is not specific regarding this matter. There is, however, a medical review board in each State Medical Society to which physicians can appeal if there are unusual circumstances under which the prescribed schedule of allowances is considered inadequate for the services rendered.

There is much confusion at the moment in the minds of everyone including the government about the operation of Medicare. It must be kept in mind, however, that Medicare is a public law that must be followed. The present contract between the State Medical Societies and the Department of Defense expires June 30, 1957, and all contracts will be subject to renegotiation at that time. Patience and cooperation are essential in the meantime while experience is being gained so that the good and the bad can be recognized and separated. Correction of mistakes and inequities can only be made as accumulated experience indicates the necessity.

Ralph T. Ogden, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

Telephones: UN 5-0587, LO 2-0836

COUNCIL MEETING

The monthly meeting of the Council was held at the offices of the Society on December 20, 1956 and was called to order by the Chairman at 4:00 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Ogden, Barker, Weld, Danaher, Gibson, Feeney, Stringfield, Gallivan, Ursone, Tracy, Otis, Archambault, Gens, Clarke, Meyers, Dwyer, Starr. Absent: Drs. Walker, Couch, Murdock, Kristan, Ottenheimer, Buckley, Gilman.

Procedure for carrying out the resolution of the House of Delegates at its meeting on December 6 calling for a referendum on compulsory social security for physicians was discussed at length and the following points were agreed upon.

(a) The referendum vote to be returned should, in addition to asking yes or no on the subject of social security coverage for physicians, include spaces for the respondents age and his signature with the note that unsigned votes will not be counted.

(b) A postage-paid return envelope will be provided.

(c) The return votes will be coded in some method so that they can be identified by Counties.

(d) Dr. Olan Meeker is to be invited to prepare a statement on the negative side of social security for physicians for publication in the STATE MEDICAL JOURNAL in accordance with the resolution of the House of Delegates. In case Dr. Meeker is unwilling to accept this assignment, the Chairman of the Council, the Managing Editor of the JOURNAL and the Executive Secretary are to select another person to prepare this material.

(e) It shall be required that both the pro and con statements shall be in the hands of the editor of the JOURNAL at the same time so that the second one to be published will not have the advantage of refuting what had been said in the first published statement.

It was voted that Clifford T. Conklin, Thomaston, be appointed a member of the Subcommittee on

School Health to fill the vacancy left by the withdrawal of Dr. Henry Louderbough.

At the suggestion of Edwin R. Connors, chairman, no action was taken upon an appointment to fill the vacancy on the Medical Advisory Committee to the State Welfare Department left by the withdrawal of Dr. Henry Louderbough.

Consideration of the School Evaluation Program referred to the Council by the Subcommittee on School Health developed a lengthy discussion. The Subcommittee had asked in the minutes of its meeting of November 29 that the State Society approve the program for the evaluation of schools and also requested the Council to inform the Subcommittee as to the best methods of securing volunteer help from physicians.

The entire project was explained by Dr. Stringfield with a special emphasis on the desirability of coordinated efforts on the part of public health authorities and school health authorities in the several towns in the State. The matter of expecting physicians to volunteer for these services was also discussed. It was finally voted that: The Council approve the coordinated efforts of the State Department of Health and the State Department of Education at the state level and suggests coordination at the local level by asking the local health directors and local school medical advisors to cooperate in the school evaluation studies.

The changes in its organization asked by the Connecticut Committee on Foods, Drugs, Cosmetics and Devices were approved as follows:

(a) The Committee be one of autonomy and as such no longer a subcommittee of the Joint Conference Committee of the State Medical, Pharmaceutical, and Dental Societies.

(b) The Committee hereafter to be known as "The Connecticut Advisory Committee on Foods and Drugs."

(c) The Committee invite the Connecticut State Department of Health, the Connecticut Pharmacy Commission, and the Connecticut Food and Drug Commission to have representation, without power of vote.

The proposal contained in paragraph 6, page 2 of the Report of the Society's Committee on Third Party Payments presented to the House of Delegates on December 6 that a committee of the Society be designated to receive information of contemplated changes in the CMS contract, was discussed. It was agreed that the Standing Committee on Third Party Payments be designated for this purpose.

A motion made by Olan Meeker on the floor of the House of Delegates at its meeting on December 6 and passed, worded as follows: "That the Council of the State Medical Society appoint a special committee to work with our national legislators toward the passage of law preventing the admission of patients with nonservice connected disabilities to Veteran Administration Hospitals."

After discussion it was agreed that the appointment of a special committee for this purpose was not indicated because there are already standing committees on the Medical Care of Veterans and National Legislation. It was voted that the Committee on Medical Care of Veterans be designated as the "Special Committee" to act under the motion passed by the House of Delegates.

Dr. Barker reported on developments of the MEDICARE Program and his report was supplemented by Dr. Danaher.

In his report Dr. Barker mentioned appreciatively the cooperation and help that had been given by Mr. Howard Bierkan, claim supervisor for Connecticut Medical Service, and it was voted unanimously that the executive secretary communicate to Mr. Bierkan the thanks and appreciation of the Council for his services.

A progress report of Building Fund was presented.

Eight student members were elected to the Society.

It was agreed that the next meeting of the Council will be on Thursday, January 17, 1957 and that the date for the first meeting of the Nominating Committee would be determined at that time.

Meetings Held in January

- January 3—Executive Meeting Medical Examining Board
Conference Committee with Osteopathic Association
- January 9—Subcommittee on Toxemia
Committee on Accident Prevention
- January 10—Committee on Public Health
- January 15—Committee on Eye Care
Conference Committee with State Dental Association
- January 16—Committee on Perinatal Mortality
- January 17—1957 Nominating Committee
- January 23—Committee on Maternal Mortality
- January 28—Connecticut Health League
- January 30—Committee on Post Graduate Education
- January 31—Council
Reception for David B. Allnhan, President-Elect, American Medical Association

National Institutes of Health 1957 Appropriations

The total appropriations to the National Institutes of Health for research-grant programs for the fiscal year 1957 will total the impressive figure of \$91.7 million. Of this amount the Cancer Institute will receive the largest share, almost \$25 million. To quote Shannon and Kidd in a recent issue of *Science*:

"Never in the history of medical science and medical education has it been so important that close, sympathetic understanding be sustained between private research groups, universities and medical schools, industrial research groups, and federal agencies. The extension of federal aid to medical research and related training over the past decade has created an unprecedented situation, one in which the actions taken federally are of such significance that wide participation in the decision-making process is essential."

1957 CONNECTICUT GENERAL ASSEMBLY

Governor, Abraham A. Ribicoff, Hartford
Lieutenant-Governor, Charles W. Jewett, Lyme
Secretary of State, Mildred P. Allen, Hartford

Treasurer, John Ottaviano, Jr., New Haven
Comptroller, Fred R. Zeller, Stonington
Attorney-General, John J. Bracken, Hartford

United States Senators

Prescott Bush, Greenwich

William A. Purtell, West Hartford

Congressmen by Districts

At-Large, Antoni N. Sadlak, Rockville
 District 1, Edwin H. May, Jr., Wethersfield
 District 2, Horace Seely-Brown, Jr. Pomfret Center

District 3, Albert W. Cretella, North Haven
 District 4, Albert P. Morano, Greenwich
 District 5, James T. Patterson, Watertown

State Senate

DISTRICT

1—Henry F. Cooney (d), Hartford
 2—Harold Borden (d), Hartford
 3—Anthony J. Armentano (d), Hartford
 4—Elmer S. Watson (r), Wethersfield
 5—Philip J. Bauer (r), Avon
 6—John M. Sanlon (d), New Britain
 7—Albert C. Snyder (r), Bloomfield
 8—Theodore F. Lynch (r), New Haven
 9—Sherman Drutman (r), New Haven
 10—Arthur H. Healey (d), New Haven
 11—Angelo J. Squillo (r), New Haven
 12—John H. Filer (r), Hamden
 13—Benjamin J. Kopacz (r), Meriden
 14—Stephen J. Sweeney (r), Naugatuck

DISTRICT

15—Domenic Castelano (r), Waterbury
 16—Peter R. Augelli (r), Waterbury
 17—Clarence G. Hummel (r), Seymour
 18—Peter P. Mariani (r), Groton
 19—Joseph H. Goldberg (r), Norwich
 20—David M. Johnston (r), Stonington
 21—John H. Shannon (r), Bridgeport
 22—A. Edward Sandula (r), Bridgeport
 23—Herbert J. Bundock (r), Bridgeport
 24—Howard A. Hueston (r), Sherman
 25—Newman M. Marsilius, Jr. (r), Trumbull
 26—Abner W. Sibal (r), Norwalk

DISTRICT

27—Benton H. Grant (r), Stamford
 28—Henry J. Dunleavy (r), Thompson
 29—Andre G. Desrosiers (r), Willimantic
 30—John A. Minetto (r), West Goshen
 31—Theodore S. Ryan (r), Sharon
 32—Benjamin L. Barringer (r), New Milford
 33—William B. Miller (r), Middletown
 34—David Parodi (r), Deep River
 35—Robert L. Keeney, Jr. (r) Somersville
 36—Florence D. Finney (r), Cos Cob
 Republicans 31
 Democrats 5
 —
 36

State Representatives

HARTFORD COUNTY

Avon, Robert B. August (r)
 Berlin, Robert Clapp (r)
 James B. Ellsworth (r)
 Bloomfield, John Frederick Bitzer (r)
 Sherman B. Carpenter (r)
 Bristol, John W. Fitzgerald (r)
 Edward C. Krawiecki (r)
 Burlington, Morris B. Hogan (r)
 Canton, Arthur W. Sweeton, Jr. (r)
 East Granby—Richard D. Seymour (r)
 East Hartford, Harry S. Burke (d)
 Louis B. Warren (d)
 East Windsor—Doris S. Stolle (r)
 Edward B. Woolam (r)
 Enfield, Peter A. Crombie (d)
 Helen B. Javorsi (d)
 Farmington, Richard C. Noyes (r)
 George S. Robotham (r)

Glastonbury, Francis B. Barnett, Jr. (r)
 Joseph A. Goodhue (r)
 Granby, Nathan K. Allison (r)
 Roger Wolcott (r)
 Hartford, Arthur G. Girouard (d)
 Thomas J. Kerrigan, Jr. (d)
 Hartland, James B. Hall (r)
 Luther B. Martin, Jr. (r)
 Manchester, Thomas J. Rogers (r)
 Ray S. Warren (r)
 Marlborough, Florence S. Lord (d)
 New Britain, Dominic J. Badolato (d)
 Samuel S. Googel (d)
 Newington, Arline M. Benson (r)
 Elmer A. Mortensen (r)
 Plainville, Gertrude Koskoff (r)
 John A. Villardi (r)
 Rocky Hill, Norman B. Little (r)
 John E. Rust (r)

Simsbury, Maurice R. Gersten (r)
 Anthony E. Wallace (r)
 Southington, Edgar F. Curtiss (r)
 Harry J. Parlman (r)
 South Windsor, Clynton B. Buckland (r)
 Suffield, Anthony Kuras (r)
 William W. Prout (r)
 West Hartford, George Schwolsky (r)
 Richard W. Sheehan (r)
 Wethersfield, Elizabeth H. Budd (r)
 Rodney B. Wilcox (r)
 Windsor, Raymond F. D'Addario (r)
 Burton C. Gustafson (r)
 Windsor Locks, Alfred J. Gragnolati (r)
 Phillip D. Greene (r)
 Republicans 43 Democrats 9

NEW HAVEN COUNTY

Ansonia, Pasquale A. Pepe (r)
 Edward F. Palmer (r)
 Beacon Falls, Clara P. O'Shea (d)
 Bethany, J. McCullough Turner (r)
 Branford, Lucy T. Hammer (r)
 Howard V. Young (r)
 Cheshire, Paul M. Andrews (r)
 Ruth F. Suarez (r)
 Derby, Frank H. Pepe (d)
 Cornelius F. Caldwell (d)
 East Haven, Elizabeth M. Croumey (r)
 Adelbert C. Maute (r)
 Guilford, Marshall N. Dudley (r)
 John McAdam (r)
 Hamden, Alice E. Hyde (r)
 William G. Kielwasser (r)
 Madison, Robert T. Cairns (r)
 Meriden, John M. Austin (r)
 Joseph S. Femia (r)
 Middlebury, Frank W. Gray (r)
 Milford, Herbert R. Elker (r)
 Diane Toulson (r)
 Naugatuck, Thomas Ratkevich, Jr. (r)
 Paul Rosa, Jr. (r)
 New Haven, Edith Valet Cook (r)
 Charles Tomasino (r)
 North Branford, Stanley T. Williams (r)
 North Haven, John F. Cipriano (r)
 David A. North (r)
 Orange, Everett W. Martin (r)
 Julia T. Wright (r)
 Oxford, C. Arthur Maybury, Jr. (r)
 Prospect, Edward H. Harrison (r)
 Seymour, Louis V. Driscoll (r)
 Willard A. Fosdick (r)
 Southbury, Sidney S. Platt (r)
 Wallingford, George M. Bennett (r)
 George B. Farnam (r)
 Waterbury, William J. Grize (r)
 Ruth A. Jones (r)
 West Haven, Robert T. Gilhuly (r)
 Axel E. Swanson (r)
 Wolcott, Carl G. Mattson, Sr. (r)
 Woodbridge, Ina Vestal (r)
 41 Republicans 3 Democrats

NEW LONDON COUNTY

Bozrah, Harold D. Winchester (r)
 Colchester, Rubin Cohen (d)
 Arthur D. Standish (r)
 East Lyme, William O. Manwaring (r)
 Franklin, Jason H. Kingsley (r)
 Griswold, Leon J. Gwiazdowski (d)
 Francis G. Liberty (d)
 Groton, Nelson C. L. Brown, II (r)
 Reginald H. Wood (r)
 Lebanon, E. Fenn Nourse (r)
 Merton M. Pultz (r)

Ledyard, Earle L. Rowley (r)
 Lisbon, Bernadette C. Maynard (r)
 Lyme, John H. Beebe (r)
 Max F. Brevillier (r)
 Montville, Stanley J. Radgowski (d)
 New London, A. Richard Cushman (r)
 Merrill S. Dreyfus (r)
 North Stonington, Roy S. Lee (r)
 Mildred M. White (r)
 Norwich, Rene L. Dugas (r)
 William E. Mackenzie (r)
 Old Lyme, James Tyler Patterson, Jr. (r)
 Preston, William A. Fleming (r)
 Carrie F. Mansfield (r)
 Salem, Joseph T. Ploszaj (d)
 Sprague, Charles L. Papineau (d)
 Stonington, James H. Allyn (r)
 Malcolm D. Perry (r)
 Voluntown, Birdsey G. Palmer (d)
 Waterford, Leon J. Bascom (r)
 Francis E. McCartin (r)
 25 Republicans 7 Democrats

FAIRFIELD COUNTY

Bethel, Mary S. Reed (r)
 John C. Streaman (r)
 Bridgeport, Ernest M. Arnold (r)
 Joseph W. D'Amicol (r)
 Brookfield, A. Searl Pinney (r)
 Danbury, M. James Keane (r)
 Nicholas A. Novaco (r)
 Darien, Marjorie Dilley Farmer (r)
 Gennaro W. Frate (r)
 Easton, Michael Svihra (r)
 Fairfield, Mary P. James (r)
 Frederick Pope, Jr. (r)
 Greenwich, Harold O. Douglass (r)
 Mark S. Matthews (r)
 Monroe, George R. Kissam (r)
 New Canaan, Mary V. Z. Cunningham (r)
 Clifford W. Hall (r)
 New Fairfield, Ralph L. Baggs (r)
 Newtown, Sarah Frances Curtis (r)
 Charles W. Terrell, Jr. (r)
 Norwalk, Louis J. Padula (r)
 John Shostak (r)
 Redding, Arthur Carlson (r)
 Robert W. Marsh (r)
 Ridgefield, Nancy Carroll Draper (r)
 Robert R. Keeeler (r)
 Shelton, Clinton B. Taylor (r)
 Bronislaw Winnick (r)
 Sherman, Edwin F. Osborn (r)
 Stamford, Hilda S. Clark (r)
 Webster C. Givens (r)
 Stratford, Rose E. Prokop (r)
 William J. Smyth (r)

Trumbull, Beulah L. Blackman (r)
 Rodney S. Eielson (r)
 Weston, John Mather Lupton (r)
 Westport, Henry Ferne, II (r)
 Helen W. Mackie (r)
 Wilton, John C. Donaldson (r)
 39 Republicans 0 Democrats

WINDHAM COUNTY

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 Joseph J. Zambo (d)
 Brooklyn, Eleanore Strunk (r)
 Canterbury, Lillian M. Frink (r)
 Charles Grab (r)
 Chaplin, Arthur J. Lucas, Jr. (d)
 Eastford, Philip R. Piper (r)
 Hampton, Elmer C. Stone (r)
 Killingly, George A. Kesaris (r)
 Robert R. Sorel (r)
 Plainfield, Antonio Demuth (d)
 Allen Mopsik (d)
 Pomfret, Kenneth P. Bosworth (r)
 Kermit B. Howe (r)
 Putnam, George H. Lewis (r)
 Elizabeth T. Shepard (r)
 Scotland, Harry N. Moseley (r)
 Sterling, Eugene J. Arcand (r)
 Thompson, Esdras Blanchette (d)
 Wilfred A. LaFleur (d)
 Windham, Robert A. Hanna (r)
 Henry J. Kucharski (r)
 Woodstock, Baruyr Peshmalyan (r)
 Harriet Sampson Pitt (r)
 17 Republicans 7 Democrats

LITCHFIELD COUNTY

Barkhamsted, Prosper F. Lavieri (r)
 Laurence H. Roberts (r)
 Bethlehem, Warren L. Hunt (r)
 Bridgewater, George R. Hambrock (r)
 Canaan, E. Alfred Davies (r)
 Colebrook, Erving Pruyn (r)
 Earl W. Smith (r)
 Cornwall, Frank E. Calhoun (r)
 Harriet L. Clark (r)
 Goshen, Francis J. Conlon (r)
 Clarence A. Vaill (r)
 Harwinton, Albert K. Bentley (r)
 Henry J. Delay (r)
 Kent, Francis C. Cady (r)
 Litchfield, Helen M. Lester (r)
 Theodore V. Marsters (r)
 Morris, Alden A. Ives (r)
 New Hartford, Nicholas B. Eddy (r)
 Rudolph E. Goldbeck (r)
 New Milford, Edward A. Ambler (r)
 John H. Noble (r)
 Norfolk, Herbert F. Robertson, Jr. (r)
 Joseph Zanobi (r)
 North Canaan, Robert D. May (r)

Plymouth, Burdet W. Oelschlegel (r)	Durham, William A. Murray, Jr. (d)	Coventry, Otto C. Miller (r)
David W. Pratt (r)	Abner B. Newton (r)	Royden F. Smith, Sr. (r)
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Salisbury, Charles R. Nash (r)	George W. Hatfield (r)	Hebron, Karl H. Links (r)
Edwin K. Paavola (r)	East Hampton, Harold C. Blankenbiller (r)	Edward A. Smith (r)
Sharon, Thomas W. Luce (r)	Roy G. Hallberg (r)	Mansfield, Foster H. Richards (r)
Bernard H. Pearson (r)	Essex, Merritt M. Comstock (r)	Edwin O. Smith (r)
Thomaston, Allan C. Innes (r)	Haddam, Lansing T. Carpenter (r)	Somers, Alvin H. Phillips, Jr. (r)
Torrington, Mary Q. Fahey (r)	Emma M. vonHagen (r)	Margaret Streckas (r)
Gennaro Piscitelli (r)	Killingworth, Gustaf A. Carlson (r)	Stafford, David J. Dickson, Jr. (d)
Warren, George B. Angevine (r)	John B. Saglio (r)	Benito Muzio (d)
Washington, May McC. Kennedy (r)	Middlefield, Joseph G. Lombardo (r)	Tolland, Harold M. Clough (r)
Thomas F. Quinlan (r)	Middletown, Marie Bouteiller (r)	James W. Metcalf (r)
Watertown, Arthur H. Russell (r)	Edward J. Cleary (r)	Union, Anna Mac Pallanck (r)
Roland W. Tyler (r)	Old Saybrook, Philip C. Fairbanks (r)	Basil A. Plusnin (r)
Winchester, Lillian E. Hutton (r)	Portland, William J. O'Brien, Jr. (d)	Vernon, Arthur M. Bateman (r)
J. Raymond O'Connor (r)	James B. Watson (r)	Franklin G. Welles (r)
Woodbury, G. Gordon Cowles (r)	Westbrook, Benjamin M. Schlossbach (r)	Willington, Gardiner H. Hall (r)
Helen Hanson Cronk (r)		Andrew Repko (r)
43 Republicans 0 Democrats	21 Republicans 2 Democrats	20 Republicans 2 Democrats
MIDDLESEX COUNTY		
Chester, Claude P. Watrous (r)		Total
Clinton, Charles H. Elliott (r)		Republicans 249
Cromwell, Ruth Leah Anderson (r)	Andover, Ellsworth L. Covell (r)	Democrats 30
Deep River, Helen D. LaPlace (r)	Bolton, Eugene Gagliardone (r)	—
John E. Larson (r)	Columbia, Laverne H. Williams (r)	279
	TOLLAND COUNTY	

Aircade Team to Take Legislative Issues to Cities

The Chamber of Commerce of the United States is about to launch a unique legislative project of interest to physicians.

A National Chamber team of experts, headed by President John S. Coleman, will strike out across the country in February aboard a chartered plane, spurring businessmen and professional people into more intensive action on issues before the new Congress.

"We intend to take national issues to be dealt with in the 85th Congress to the doorsteps of the people themselves, all over the nation," Mr. Coleman said, adding: "We want to give them a clear understanding of these issues, to explain their background, and to demonstrate why it is in the interest of everyone to organize and be prepared to present their views and recommendations as the issues claim the attention of Congress."

Many of the issues to be discussed at these all-day meetings affect medicine and the profession. Programs up for discussion and study include the Hoover Commission recommendations; government in the health insurance business, either directly or indirectly; social security; government spending, and taxes—subjects which are of vital interest to medicine. Consequently, physicians will want to attend these meetings when the Chamber team visits their communities.

The aircade schedule follows:

February 4, Los Angeles, Hotel Biltmore; February 5, Oakland, Claremont; February 6, Salt Lake City, Utah Hotel; February 8, Seattle, Olympic; February 11, Minneapolis, Nicollet; February 13, Chicago, Sheraton; February 14, Cincinnati, Netherland Hilton; February 15, Dallas, Statler; February 18, Atlanta, Henry Grady; February 19, Pittsburgh, Webster Hall; February 20, Hartford, Statler; February 28, Detroit, Sheraton-Cadillac.

INSURANCE AND THE PHYSICIAN

ARE THE DOCTORS MEETING THE CHALLENGE?

W. H. HORTON, M.D., *Windsor*

While parts of this paper, particularly in the first half, will be of more interest in the Northwest Section of the country where the paper was delivered and for which it was written, we believe that the greater part of the paper should be of interest to all practicing physicians who are interested in voluntary health insurance and its relationship to practicing medicine.

The Author. *Executive Director and Director of Medical Services, Connecticut Medical Service, Inc.*

FACTORS AFFECTING THE ANSWER

It is not possible to provide any reasonable answer to the question, "Are the Doctors Meeting the Challenge?" except as a generalization. Generalizations have the weakness inherent in any expression of a so-called "average" opinion; it would be impossible to document some of the assumptions on which the generalization is based.

Admitting the weakness of any generalization we can still find some answers to the discussion question. For example, if we consider organized medicine as a whole the best answer we can make is that, to the degree that they understand the problem, doctors are meeting the challenge very well. If we limit the doctors under discussion to those who actively support Blue Shield Medical Care Plans, we can answer more positively. The latter physicians are aggressively meeting the challenge and they are developing an increasing awareness of the great importance, scope and depth of the problem.

If we answer the question in terms of areas of the country we are able to cite situations where the challenge is being met to the highest degree consistent with the sound development of an acceptable solution to the problem; and conversely, we can

easily cite other local areas in which little, if anything, has been or is being done to meet the challenge.

In the latter situations the reason for the inactivity is probably because of the failure to realize that a challenge exists. The importance of the challenge to practicing physicians is greatest in urban centers and least in less populous areas. This does not mean, however, that the patients in the latter areas are any the less interested in a satisfactory solution to the problem, but their interests are not well organized and, therefore, are less effective. The demand for extensions of medical care insurance are greatest where workers are highly organized. We may expect, therefore, that physicians who practice where the demand for coverage is greatest will become more familiar with the problem and the challenge it presents than will their colleagues in other areas.

The challenge to the profession is the necessity to provide broad insurance coverage of all professional services of doctors of medicine at nominal cost.

Those of us who are familiar with the day by day life of practicing physicians are not inclined to be as disturbed by the apparent lack of interest of many physicians as are those less familiar with doctors.

When one recalls that the ethics of medicine place a traditional priority on services before fees, we have the basic reason for the average doctor's reticence to be involved in the economics of medical

Presented at the Western Conference of Prepaid Medical Service Plans, Sun Valley, Idaho, October 12, 1956

practice. We all realize that as a practical matter most physicians have avoided for generations, any discussion of fees with their patients because they have felt that the patient might infer that they were more interested in the financial returns than they were in his welfare. Even today, when organized medicine strongly urges its membership to discuss fees with patients prior to the rendering of elective-type services, the vast majority of physicians do not wish to discuss fees with patients before services are rendered.

This attitude toward charges on the part of physicians could itself be the subject of a lengthy discussion. I cite it only to provide background for our discussion of the physician's reaction to the challenge.

If we are to measure intelligently how well doctors are meeting the challenge, we must first clearly delineate the extent of the physician's responsibility. Just what part should the doctor be expected to take in this matter?

EXTENT OF PHYSICIAN'S RESPONSIBILITY TO THE PROBLEM

The responsibility which every practicing physician has toward voluntary medical care coverage is an extension of the basic ethical relationship of the physician and his patient which has been the time-honored guide for good medical practice. Blue Shield Medical Care Plans are merely a practical application of the ethical principles to the current economic situation of medical practice.

The significant development of voluntary medical care under the sponsorship of organized medical units provides ready proof of how willingly practicing physicians have accepted their responsibility and are meeting the challenge. There is no parallel in our history, except as a matter of prime self interest, in which a business or a profession has not only continued to provide an increasingly effective service but at the same time has lent its best efforts to helping the people to be able to enjoy the benefits of the service.

I believe that sincere participation in a Blue Shield plan provides the most practical sort of proof that an individual doctor is aware of the challenge and is prepared to meet it.

The Service Benefit concept of Blue Shield by which the participating physician guarantees his services without additional charge to the patient in advance of accepting, and often without knowing

the amount of, the plan payment is without a counterpart in American life.

Service Benefits are fixed fees and it is unfortunate that the general public is not more adequately informed of the willingness to accept fixed fees for services to the lower income groups which American physicians have already demonstrated. Participation requires acceptance of certain conditions under which the physician will practice and which heretofore he has never had to accept. Participation requires a legal contractual agreement to accept fixed fees for services rendered to certain income groups; it requires the physician to forego his right to make his own charges; it requires that the physician accept the decisions of a professional policy or adjudication committee of the plan as to what charges are reasonable, and what professional policies will prevail. In short, it requires that the physician provide practical proof of the often quoted medical axiom that the doctor's chief interest must be the welfare of his patient. Participation extends the meaning of "welfare" to cover not only the patient's health but his economic ability to meet the costs of maintaining his health as well.

Participation also usually involves agreement by the physician to accept pro rata payments of specified fees if it should become necessary to do so to insure the financial stability of the plan. In some plans it has been necessary to invoke this important obligation assumed by the participating physician. Under this type of agreement participating physicians become coinsurers with the plan in guaranteeing the benefits provided. Participating physicians are the most important asset of every Blue Shield Medical Care Plan even if technically they are not admitted on the balance sheet.

We can be very definite in stating without qualification that participating physicians in Blue Shield Service Benefit plans are meeting the challenge because such participation involves much more than "lip service."

We should concern ourselves now with how much better the challenge can be met by these physicians who have not hesitated to provide, not only leadership, but day by day dedicated services in working out a satisfactory solution to the economics of medical care problem.

The most important goal to be sought in Blue Shield is the development of increased confidence by participating physicians in the leadership of their Blue Shield plan. I have said this is the most import-

ant because it seems to me that we are misdirecting our efforts and wasting the doctors' time and our own when we try and keep each physician informed of all we are able to learn about plan administration. There seem to me to be two good reasons for this viewpoint. First, the practice of medicine is the physician's primary interest and the necessity to keep abreast of the continually changing techniques requires all the time that a doctor is able to spare from the practice itself. He is being urged continually to take a more active part in community life, in politics, and in the hundreds of projects which have a collateral interest with medicine. Surely he cannot do all these things well and still practice good medicine. I think he will appreciate us sparing him the necessity to become a medical economist. Second, if it takes all our time and efforts to determine the contents of our contract, to add or exclude benefits, to understand and meet the problems of competition, and to anticipate the approval or disapproval of our controlling authority it is ridiculous to expect practicing physicians to be able to meet problems of the plan with the same background. Every participating physician cannot expect to operate the plan as his personal affair. He must delegate the responsibility and administration to his representatives. There may be a place in the army for the so-called "guard house" lawyer but surgical or diagnostic skill is no qualification for underwriting. If the physician has confidence in the administration of his plan he knows that the policy decisions are not made arbitrarily but reflect the best judgment of the plan administration.

Physicians will not lightly delegate broad responsibility to plan administration. If there is one aspect of Blue Shield plans of which physicians are inherently afraid it is the fact that participating agreements provide the plan with a certain degree of control over the physician; they wish to be certain that such control is not abused.

How can we increase the confidence of the physician in the administration of the plan? We can see to it that the boards of trustees or directors and the administration of the plan fairly represent the interests of the physicians who participate. We can see to it that means are worked out whereby more practicing physicians act in advisory positions with the administration; that tenures of office are limited so that the experience to be gained may be better distributed throughout the practicing profession. Furthermore, and most important of all, the plan

must deal fairly with its physicians. All policies must be applied equally to all participating physicians and all members. The physician and the member are entitled to prompt payment of the claim. The physician is entitled to be paid the amount which he may reasonably expect is due him from the administrative information provided him. If the claim cannot be paid, or must be paid in an amount different from that stated in the literature, the physician is entitled to a clear explanation of the reasons or the policy involved.

Creating the maximum direct physician participation in the administration of the plan, and dealing fairly with him in the handling of day-by-day claims, will do much to create confidence in the administration of the plan whereby the participating physicians will be more willing to meet the challenge provided by the voluntary medical care problem.

The question of the physician's responsibility to aid in the providing of voluntary medical care insurance has interested me a great deal and I have noted during the past that two of the more serious false premises which have characterized a number of the efforts to find a solution to the medical care insurance problem have been:

(a) The easy assumption that since the responsibility for providing medical care is that of the medical profession, it somehow is equally the responsibility of the profession to provide means of meeting the costs of medical professional services, or

(b) If the doctors were unable to arrange for all of the medical care desired, the government should step into the picture and by paying the physician to render the services, provide an easy solution to the problem.

It is easy to understand the origin of some of this thinking because the traditions and ethics of the medical profession have, since its beginning, shaped the pattern that the practicing physician would not only render his professional services but would arrange for delayed payment of his fees on a usual liberal basis or in many cases forego it entirely.

In this respect the medical profession is unique. No other profession, trade, or business accepts the responsibility of devising means by which its profession, trade or business services may be paid for except as a matter of prime self interest; nor does the general public expect them to.

It would seem that since the participating physician through Blue Shield has led the way in indicating a practical solution of the problem, others in the business and professional world should accept their proper share of responsibility to complete the task that has been so well begun. If not, it is inevitable that the commitments of the participating physician in the Service Benefit Blue Shield plan which create a unilateral contribution to the solution of the problem, will in all probability eventually be considered unsatisfactory by the physician.

The cost of the medical care problem concerns every American; its solution cannot be expected by the efforts of physicians alone. If every business and professional man would accept the same responsibility and make a contribution equivalent to that which is being accepted and contributed every day by participating physicians there could be no doubt of a successful solution to the insuring of adequate medical care for all the people.

While I have stated my conviction that the physician has an important and basic responsibility in meeting the challenge we should be just as clear in delineating the limits of that responsibility. I believe the physician's primary responsibility to meet the challenge begins and ends with the provision for the professional services of doctors of medicine.

LIMITS OF PHYSICIAN'S RESPONSIBILITY TO THE PROBLEM

I do not think it is the practicing physician's responsibility to involve himself in making arrangements for the coverage of ancillary medical care services such as drugs, ambulance service, private duty or public health nurses, appliances, convalescent or nursing home care, and hospitalization. While these services are all part of medical care it is not the responsibility of the practicing physician to arrange for their coverage on an insurance basis. Their coverage is, of course, a collateral interest of the physician since unless these services are available the patient cannot be provided with proper care. The primary responsibility for the coverage, however, belongs to others and in this present discussion of how well the several interested groups are meeting the challenge I hope there will be some comment regarding these ancillary services.

In my conversations with participating physicians on many occasions during the past years it has been pointed out to me that the contribution of the participating physician in rendering Service Benefits is

unique in the medical care field. There has been more than a suggestion that the physician's willingness to accept the Service Benefit fixed fee has not tended to reduce (or at least prevent a rise in) the cost of medical care. It has only enabled the patient to have available more funds to meet the expenses of a greater quantity of ancillary care or even personal luxuries.

I can recall that in the days before Blue Shield was important in the surgical field one of the chief arguments used to urge physicians to support Blue Cross was the statement that if the patient had his hospital bill paid by Blue Cross he would be able to use the funds which would have gone to pay the hospital, to pay his physician. I always felt that this specious argument unpleasantly reminded the doctor of his customary position of being the last to be paid for his services.

Now that Blue Shield is providing prompt payment for physicians' services and the participating physician in turn is providing Service Benefits, we should avoid the serious error of having the funds which the physician does not collect by providing Service Benefits, diverted to the purchase of ancillary services or personal luxuries. It is not, or at least it should not be, the intention of Blue Shield plans to restrict the income of the participating physician with the fixed fees of Service Benefit programs in order that the patient will have more money to give to those who provide ancillary medical services. The doctor is just as deserving of being paid in the full value of his services as are any that render medical care services. Thus far, except for Blue Cross hospitalization, there has been little evidence of any willingness to provide ancillary services on a fixed fee basis similar to the Service Benefits provided by the physician for his services.

OTHER RESPONSIBILITIES OF THE PHYSICIAN

Having cited the physician's responsibility to the problem and outlined the reasonable limitations of that responsibility, we should further comment on the physician's responsibility to himself, his colleagues, and his Blue Shield plan to maintain the integrity of them all. Probably the greatest single attribute of a Blue Shield plan is that it carries into its day by day operation, at the highest level, through the sponsorship by a group of organized medicine, the traditions of medical practice. This automatically implies that it is the duty of every participating physician to protect both the member and the plan against exploitation. I have hesitated

to use the word exploitation since it carries with it the implication of dishonesty and the obligation of each physician to protect the plan and the member against dishonesty is too obvious to require a statement here. What I have in mind is the difficult problem of fairly evaluating one service in relation to another. This is exceedingly difficult to accomplish and yet if it is not realized, certain physicians will be overpaid at the expense of others. The very nature of medical practice does not lend itself well to rigid categorization and we all realize that it is impossible to fix certain fees. Usually we meet the difficulty by providing "individual consideration" or some such term to indicate that we will deal separately with each particular claim. Similar situations are those in which multiple injuries are sustained and it may not seem reasonable to make the over-all payment the sum of the fees for each individual procedure as specified in the fee schedule. All situations of this type call for the utmost fairness on the part of those who have the responsibility of plan administration if every participating physician is to be treated equitably. In turn, each doctor must be meticulous in reporting the extent of his professional services. The plan should exercise due care that their payments for procedures with discretionary fees do not reflect their opinion of the literary ability of the doctor. The ability to describe the treatment of a surgical problem has no bearing on the professional skill which was involved.

Another important consideration in maintaining the integrity of all involved is that the contracts which are sold by the Blue Shield plan be arranged to provide reasonable benefits. We are frequently reminded that many fee schedules are inadequate and the charge in most cases is true. Less frequently is it brought to our attention that the provisions of some of the contracts which are being sold and the fees which are specified for certain procedures are over generous and yet this also is quite true.

A moment ago I dismissed the consideration of deliberate dishonesty on the part of physicians as being so obvious a concern of all doctors as to not require comment. There is one related aspect of deliberate exploitation, the importance of which sometimes escapes the practicing physician. When through statistical analysis of disbursements, or other suitable control measures, factual evidence is developed by the plans' administration that false claims are being submitted by a physician, the professional policy or adjudication committee of the plan should

be forthright in its action. Any such actions which are properly taken should have the unqualified support of all participating physicians of the plan.

Regardless of any and all controls which may be maintained to insure that the plans' funds are being properly expended the most important factor in the operation of a Blue Shield plan, and it is essential, is the integrity of the practicing physicians.

There are now two important developments in the current medical care picture of particular concern to Blue Shield plans and about which every practicing physician should be well informed. These are major medical types of insurance contracts and the "medicare" program for dependents of the uniformed forces.

CATASTROPHIC INSURANCE

In the past few years we have seen the rapid development of so-called major medical type insurance of medical care. I wish that the scope of our topic today was such that we might spend more time in analyzing the latest trends in this type of coverage. It is being advanced by many, including Blue Shield plans, as the panacea which will provide the cure for all the economic ills of medical care. My opinion of it (at least the greatest part of the types of contracts most recently written) is that they are not only not panaceas, but as with all drugs (if we may continue to use the metaphor) they have some very dangerous side reactions which may well lead to undesirable results as far as the independence of medical practice is concerned. It is upon these aspects of major medical, catastrophic, or "dread disease" insurance that I would like to comment.

Fee schedules are not popular with most practicing physicians. Those who work in the arrangement of fee schedules are familiar with the inadequacies of their present development. The degree of standardization of treatment and professional policy which is necessary for proper operation of a medical care insurance plan is annoying to many practicing physicians. Many object to even the minimum degree of control which the most lenient administration finds necessary. Nevertheless, all of these less-than-pleasant aspects of the insurance coverage of medical care are basic to the operation of most Blue Shield plans. It is to the credit of all those involved in Blue Shield that most practicing physicians have voluntarily accepted these aspects of Blue Shield and it has grown to be the great voluntary medical care enterprise which it is today.

It is being brought to the attention of practicing physicians that most major medical expense contracts do not have fee schedules and the physician may make any charge which he feels is reasonable. In addition, he is not required to conform to decisions of a professional policy or adjudication committee such as usually is the case in Blue Shield. In these two considerations lies the one of the serious competitive aspects to Blue Shield which major medical expense insurance represents. To recall our topic of discussion, "Are the Doctors Meeting the Challenge?" I think we might well spend a few minutes to ask ourselves whether this particular mechanism for meeting the challenge is as good as we have been led to believe.

Major medical expense insurance has been presented to the public with enthusiastic backing from a large part of the insurance industry, a sizeable part of the medical profession, and increasing support in the daily press. The original goal of this type of contract was to provide the policyholder with long term protection against the so-called "catastrophic" or "dread" diseases. This admirable objective was to be accomplished by establishing deductible amounts in the policy which required that the patient expend some of his own funds before the benefits of the major medical policy would be available to him. It was felt that these restrictions would eliminate a large number of so-called nuisance claims which are expensive to administer. As a further control, the patient was required to pay a percentage of the physician's charges each time benefits of the major medical policy were utilized. This coinsurance factor was considered helpful as a control mechanism since the fact that the patient was continually required to pay a portion of the expenses of his treatment would give him an interest in what was being charged. These two important aspects of major medical insurance were cited as the proper way to deal in medical care insurance rather than by so-called "first dollar" payments for which Blue Shield had long been criticized.

With this brief background let us note present developments after only a few brief years of experience. In general, the trend is to lower the deductible amount and to require less of a coinsurance factor from the patient. Contracts are now being written with deductible amounts as low as \$25 and coinsurance factors of less than 20 per cent. It seems clear with contracts written in this trend that there

no longer is much concern with the effect on the cost of medical care which the reduction of these controlling factors will have. A detailed study of some of the new major medical contracts provides convincing evidence that they begin to look more and more like remodelled versions of the "blanket expense policy" which used to be a favorite of the industry. The direction and intent of such major medical contracts seem to have shifted from the original objectives (if I understood them correctly) of providing long term coverage for the treatment of chronic disease or severe injuries or accidents, to a program which simply contemplates payment of physician's charges and associated expense with little or no contribution by the patient.

Such contracts are, of course, popular with patients and with physicians too. Obviously it is to the physician's advantage to have his regular charges paid substantially, or in full, without reference to fee schedules. It is equally obvious that the abandonment of controlling factors and the payment of so-called "going rates" places medical care provided under such contracts as part of the constantly upward inflationary spiral.

Probably the most dangerous aspect of this type of major medical expense insurance is the fact that everyone concerned is pleased with the way it operates; the patient likes the low deductible, the physician likes the higher fees, the insurance carrier likes the business, and as long as the employer who is paying part or all of the cost feels that his negotiations with labor were satisfactory not even he is unhappy. In such an atmosphere of mutual happiness it is obvious that criticism will be something less than welcome. Nevertheless since, as we have pointed out, such programs contribute to the constantly increasing cost of medical care the ultimate disaster will demonstrate the truth of the criticism which may not be acceptable at this time.

The cost of such insurance is based on an experience-rated contract and it is the employer who is paying the bill. It seems apparent that as long as he is willing to meet the cost of such contracts they will continue to increase in popularity. When the cost reaches a point, however, at which the employer feels he can no longer absorb it, what is to be the end picture of this type of major medical expense insurance?

If the employer cannot eventually pay the cost there is obviously only one other agency which can do so—the government. I believe that if you will

make a thorough study of contracts written in this latest trend of major medical insurance and project them into the future it will be your considered opinion, as it is mine, that such contracts may well provide the easiest method by which voluntary medical practice can lose its fight against governmental control. This is not to say, by any means, that all major medical type contracts are unsatisfactory. Those which include significant deductible amounts and coinsurance factors are an important means of meeting the costs of real so-called "catastrophic" medical care costs. It is the tendency to continually reduce these important aspects of such contracts as an expedient to obtain the business that is disturbing.

The deficiencies of major medical insurance are not by any means limited to the cost factor although that is one of the most important. As part of the mechanism being developed to meet the challenge it is extremely deficient in measuring up to what the solution of the problem requires. It is available, at least at a cost that can be afforded, only to employed groups. While such insurance is important (or could be) to those who are working, the very fact that they are at an age which permits them to work every day indicates that their need for such protection is relatively less than it will be when they are no longer able to work. In the years after retirement when costs of adequate medical care are so important to us all, major medical expense insurance is not available to us.

BLUE SHIELD VS. "CATASTROPHIC" INSURANCE CONTRACTS

I cannot leave this discussion of major medical insurance without bringing to your attention how poorly understood by the general public are the relatively superior merits of the better Blue Shield contracts. A short while ago with a fanfare of publicity that earned headlines in most eastern papers, it was announced that one of the nation's largest employers had agreed to provide one of the best programs of medical care coverage for the employees. The details of the contract, when I finally had the opportunity to read the employees' handbook, consisted of a routine basic contract with a \$250 maximum and an ordinary major medical \$100 deductible contract on a 25 per cent coinsurance basis. There was certainly no aspect of the contract half as interesting as would have been a report of a man biting a dog but it still had been considered major news. More interesting to me, however, was

the provision for coverage following retirement of the worker. So there will be no question as to whether I am providing factual information I will read you the excerpt from the employees' handbook. "The total amount of benefits payable on account of you and your wife during the remainder of your lifetime after you reach age 65 whether for one cause or different causes, will be limited to a total of \$1,000 in the case of an employee with at least 10 but less than 15 years of service and \$1,500 in the case of an employee with 15 or more years of service . . ." It was, however, pointed out that should these sums not prove adequate to meet his needs he can borrow against his life insurance. Any money so borrowed and not repaid would, of course, be deducted from the death benefit when his life insurance became payable. The provision of such mediocre benefits in the years when these retired workers will no longer be eligible for medical care insurance should provide you with some grounds for considering how well this much-publicized type of major medical expense insurance is meeting the challenge.

It would be pointless for me to criticize the contract I have referred to if I could not suggest a better alternative. I can tell you that retirees of all of the enrolled groups in Connecticut Medical Service, Inc., are guaranteed an option to continue after they retire the same basic contract that was in force while they were working and this includes one of the largest aircraft corporations in the country. It not only provides the identical coverage but if the retired employees are of sufficient number to be handled as a group and their membership charges deducted from the pension payments, they would have the same membership charges as for active employees. If the retired employees cannot be handled as a group they are permitted the full coverage with a nominal 20 per cent increase (25¢ a month) in membership charges. The Service Benefit provisions of our contract are, of course, still available to the retired employee.

I trust you will excuse the use of a personal example in this discussion but I thought it might be a good time to provide an answer to those who have frequently asked, "Why do we have to have Blue Shield?" or "What can Blue Shield do that insurance companies cannot do better?"

"MEDICARE"

The second of these two important developments, "medicare" for dependents of uniformed services,

is so new that most of our comment must be in the nature of speculative projection rather than a review based on experience. The program, of course, does not become effective until December 7 of this year* and in many areas it seems questionable whether that deadline set by the national legislation can be met. The medicare program in brief is the provision of certain medical care services to the dependents of all uniform service personnel on active duty on the basis of a fixed fee schedule. The schedule can be developed by the state medical society if it wishes to do so and the Department of the Army has been authorized to develop and administer a schedule if the state medical society in any area is unwilling to do so. There are some very important aspects to this program which should not escape the attention of every practicing physician. These are:

1. The fixed fees will apply for the services regardless of the income status of the individual who provides the support of the dependent. This is, of course, the equivalent of a total Service Benefit program.

2. The physicians who will provide the services are being given an opportunity to arrange their own schedule of reasonable fees.

3. The government has stated that it does not wish to be the beneficiary of "cut rate" medicine; neither does it wish to pay excessive fees for the services provided.

4. Since the expenditure of federal funds is involved it is to be anticipated that all payments will be subject to audit from the highest echelons throughout the program, possibly even to the individual physician's office.

5. Each state medical society which chooses to participate in the program may perform the administration itself or arrange for a contracting agent, presumably either the Blue Shield plan which it sponsors or any licensed commercial insurance carrier.

6. The introduction of an uninsured medical care program such as "medicare" for such a large group of people as the dependents of uniformed forces is a significant landmark in the steps which are being taken to meet the challenge. The Blue Shield plans involved or whoever acts as contracting agent will serve as a custom claims processing unit. It seems reasonable to suppose that if "medicare" is successful it will serve as a pilot project and other large

groups affiliated with the federal government through employment or as beneficiaries may well be covered under similar programs. It is too late now to argue the merits of a program such as "medicare." It is now public law and it is the obligation of each citizen to do his best to make the program successful.

While many would disagree with the program as it is set up, I believe that the fact that units of organized medicine are being given the opportunity to arrange for the administration of the program within their areas and that the practicing physicians who will render the services are able to set their own reasonable fee schedules are extremely important provisions of the program. While some of us might have wished to write the program differently I think we must all agree that excellent provisions have been made for the protection of voluntary medical care.

BLUE SHIELD CAPACITY TO MEET THE CHALLENGE

How well is organized medicine prepared to use its best efforts in meeting the challenge? All seventy six Blue Shield plans in the United States and the Territories are sponsored by units of organized medicine such as state or county medical societies. In most plans there is, and has been, a close liaison between the sponsoring society and the plan in promoting the Blue Shield movement. It must be admitted that in some areas there has not been a sufficiently continued interest in the growth of the plan by the society which sponsored it.

At the national level of organized medicine there appears to have been in the past a lack of recognition of the importance of the Blue Shield movement to the people and physicians of this country and of the fact that all Blue Shield plans are sponsored by the component societies of the American Medical Association. In addition, the majority of the members of the American Medical Association are participating physicians in Blue Shield plans. Recently, the House of Delegates commended the Blue Shield participating physicians for their work toward solving the economic problems of medical care. At the present time there is a substantial number of the members on the Council of Medical Service of the AMA (which is the organizational unit most concerned with medical economics) who are familiar with the increasing importance of Blue Shield to the preservation of voluntary medical care. I believe we may expect, therefore, there will be a continuing

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and increasing interest in Blue Shield by the American Medical Association.

What should be the position of Blue Shield if it is to continue to meet the challenge of voluntary medical care insurance? I have tried to tabulate briefly seven guide posts, which in my opinion, are essential if Blue Shield is to continue to be the constructive force in the future which it has been in the past to provide better medical care coverage for the American people:

1. We must maintain the long range objective of providing complete coverage of all the professional services rendered by doctors of medicine at the lowest possible cost to our members in the lower income groups; we must provide substantial indemnities for all professional services rendered by doctors of medicine to those in the higher income groups. In the pursuit of these objectives we must write sound, equitable contracts; we must not try to gain the good will of practicing physicians on the basis of bonus payments for services; and we must design our contracts to adequately meet the ever changing methods of medical treatment. We must continue our leadership in providing protection against the cost of medical care but we must follow, not lead the practicing physicians in their changing methods of treatment.

2. We must work toward complete benefit programs which will be as renewable as our own basic contracts. We must not be satisfied that contracts with either dollar or time limits for the treatment of specific causes are adequate to meet the needs of the people.

3. We must eliminate the restrictions of age, pre-existing conditions or disabilities, and size of group in which a person is employed, as restrictions to the use of our benefits by those who may well need them the most. We must remember that our work is far from complete if we are able to provide coverage for only those who are gainfully employed. In this particular aspect of medical care insurance, the most important in my book, Blue Shield plans have made significant achievements which our competition has not chosen to challenge.

4. We must retain in our contracts every reasonable control that is necessary to the satisfactory operation of sound underwriting. The laws of insurance underwriting are just as realistic as those which govern other aspects of our economic life. They

cannot be changed simply because some clever fellow wishes to be expedient in meeting the demands of a large account, without eventually incurring disaster.

5. We must restore fee schedules to contracts, from which they have been eliminated, so that we will have at least a base line from which all benefits may be paid on a rational basis. It makes little difference how extensive a benefit program we may wish to write, as long as we have a base line on which our contractual fees are firmly planted. Fee schedules need not be inadequate and we should devote our efforts to their development on the most adequate basis possible. It is as important and as foolhardy to attempt to control the increasing costs of medical care without fee schedules in insurance contracts as it would be to sail a boat across the ocean without the use of navigation aids.

6. Blue Shield must be prepared to lend every effort in providing the services requested by its sponsoring medical organizations to make the medical care program of the federal government effective. There is a large field of potential business as similar medical care programs are arranged for other large groups of workers for, or beneficiaries of, the government.

7. Blue Shield must not be side tracked from its primary purpose of helping all the people meet the costs of their medical care under the sponsorship of organized units of medicine or stampeded by brilliant new solutions to the medical care problem which are introduced on the medical care scene by competition. If our competition were writing medical care coverage so much better than Blue Shield we would not today be providing protection for more than one out of every five people in the entire country. If our competition had known ten or fifteen years ago how to write the type of coverage of physicians' services that the people wanted there would have been no necessity to establish Blue Shield plans.

"Are the Doctors Meeting the Challenge?" Despite the weaknesses of generalization which I noted earlier, there is no question that practicing physicians, particularly those who actively support Blue Shield Medical Care Plans, are meeting the challenge of the cost of the medical care problem on the very practical basis of day by day work, and more effectively than any of the other interested groups which have an equal responsibility.

PRINCIPLES FOR COOPERATION

The Connecticut State Medical Society The Connecticut State Bar Association

INTRODUCTION

These principles are being promulgated with the hope that they will prove helpful to the members of each profession and the public they serve.

In recent years there has been an increasing number of cases requiring medico-legal testimony and there has ensued a need for improved and closer cooperation between the medical and legal professions.

A substantial part of the practice of law and medicine is concerned with the problems of persons who are in need of the combined services of a lawyer and a physician. Each must keep in mind the differences in the capacities and characteristics of the practitioner of each profession and that while law and medicine may each be termed a science, each is an inexact science and such inexactness is and always will be accentuated by the human limitations of its practitioners.

These principles are based on the recognition of a bilateral responsibility for the unhampered solution of medico-legal questions and indeed, all matters of mutual interest and concern to the two professions. Of fundamental importance is a primary acknowledgment of the duty the members owe the professions themselves and the public served by them.

These principles are not rules and regulations but they are goals worthy of the aims of each profession. No set of principles can be so all inclusive as to define each and every detail of successful cooperation. Most situations will be amenable to easy solution if the members of each profession always honor the lofty objectives sought by their respective professions.

Doctors and lawyers have much in common. Each is bound by a code of ethics dedicated to attaining the most worthy objectives inherent in the trust placed in each profession by the community served. The State licenses the individuals of each profession to administer to the needs and to carry out definite

social responsibilities to the public. The State at any time may call upon either profession for an accounting of their stewardship to this public trust. Each profession is dedicated to the principle of free choice: free choice in the selection of a lawyer to safeguard an individual's freedom and rights as citizens; freedom of choice in the selection of a physician to safeguard the health of the individual.

Having in mind these introductory remarks we herewith endorse and urge upon the members of each profession the following principles.

I

The medical profession recognizes its obligation to keep adequate records in order to supply to a patient's attorney all information regarding the patient-client's medical history provided the physician has received proper authorization from the patient. The physician in his report to the attorney should in such a manner report the patient's medical record that the attorney may readily understand the circumstances of illness and injury, the extent of disease, the degree of disability, the progress of treatment, the future course and probable costs. Confusing medical terminology should be avoided and the exposition of the physician should aim at such clarity that a nonmedically trained individual can understand his report. If a physician is unable to state a complete medical evaluation and prognosis he should so notify the attorney and suggest to the attorney that he request a further medical report at an appropriate time.

Physicians should recognize the importance of promptness in providing a patient's attorney with such information from his medical record which is of importance in realizing the patient's legal rights. Under no circumstances is a physician to divulge a patient's medical record without the authorization of the patient or his attorney.

When a physician has agreed to offer testimony on a case is approached by the attorneys or other representatives for other parties with adverse interest, he should be frank about his prior commit-

ment, notify the attorney of the party for whom he has agreed to testify and thereafter be guided by the advice of the latter's attorney.

Under no circumstances is a medical witness justified in suppressing medical evidence required by the courts in its search for justice.

II

The attorney should not counsel or maintain any suit or proceeding which shall appear to him to be unjust or any defense except such as he believes to be honestly debatable under the law of the land. Since no medical witness appears in the courts except those called by the attorneys or the court itself, it is of the greatest importance both to the attorney as well as the physician that no improper testimony be allowed. It is improper for an attorney to seek to color the professional opinion of the physician contrary to the ethics of both professions. Such is beneath the dignity of each profession.

III

Under circumstances which require the presence of a physician in court, every effort should be made to arrange a pretrial conference between the physician and the attorney. During the conference the attorney should acquaint the physician with what will be expected of him in court and the physician should take this opportunity to review the patient's medical history with the patient's attorney.

IV

Our system of justice depends upon being able to require a citizen's attendance at a trial. No doctor should take offense at receiving a subpoena. However, attorneys should exercise their best professional judgment in having subpoenas issued to physicians. Recognizing the demands of a doctor's profession, a lawyer should make every effort to avoid unnecessary inconvenience by giving the doctor as much advance notice as possible as to the time and circumstance of his appearance in answer to the subpoena. The doctor should recognize his obligation to his patient and the courts by appearing when requested.

V

The physician in court is a witness and as such should never assume the role of the patient's attorney. The physician should be courteous to the cross-examiner whose function is to ascertain the accuracy of the medical testimony. Attorneys, in turn,

should recognize the physician as a witness and treat him with the respect and consideration due an aide to the court in its attempt to reach justice. The physician should be guided by the thought that he is a consultant giving as accurate opinion as he is capable of presenting.

VI

Each profession is dedicated to serve people regardless of race, religion, rank or ability to pay. When the financial circumstances of the patient justify, the physician is entitled to reasonable compensation in consideration of his time for conferences, preparation of requested reports, medical care rendered, travel costs, and court and other appearances. The attorney is obligated to explain these facts to his client. Under no circumstances should a physician enter into a financial agreement on a contingency basis. Such a practice should lead to the charge that the physician witness has an interest for being partial in his testimony. Agreement on the payment of the physician for his services should result from free discussion between the patient, the doctor, and the attorney. It is often advantageous to request the patient to permit the lawyer to pay the physician directly out of any recovery which may be had in a particular law suit because the doctor's contributions in time, preparation of reports, court appearances, etc., are seldom known to the patient unless the attorney explains these matters to his client. It should be held professionally reprehensible for an attorney to make settlement of a case without providing for the physician's fee after he has made an agreement with the physician witness with the client's approval.

VII

The medical and legal professions jointly urge that all persons suspected of having committed a capital offense shall immediately be examined by a panel of not less than two psychiatrists designated by the Commissioner of the State Department of Mental Health.

EXHIBIT A

WHAT SHOULD BE INCLUDED IN A PHYSICIAN'S REPORT

In writing the report the following information should be included:

A. Date, time and place of first visit.

B. History (very brief) of accident; i.e., patient fell down a flight of stairs landing on her back at the bottom of the stairway.

C. First examination: Patient complained of low back pain, neck pain and in general areas over her entire spine; examination disclosed, etc.

D. Subsequent examinations and treatment showed what? Include evaluation of pain, course of therapy, confinement to hospital or home, referrals to other doctors.

E. Diagnosis: Include injuries reasonably probable received and any reasonably probable effect the injuries received did have in the precipitation, aggravation and causation of any other injury or disease.

F. Prognosis: Including an evaluation of disability, past present and future, and the necessity for future medical treatment and surgery.

The writing of such a report, the preparation for trial and the ability to give credible evidence in an intelligent manner depends on five things:

1. A thorough consideration of all the aspects of the patient's case.
2. A knowledge of what is meant by "reasonably probable causation."
3. An understanding from a legal point of view of the factors which go into the evaluation of pain.
4. An understanding from a legal point of view of the factors which go into the evaluation of disability.
5. An examination of authorities and opinion in an uncommon, unusual, very important or vigorously contested medical opinion.

RECOMMENDATIONS FROM COMMITTEE ON EYE CARE CONNECTICUT STATE MEDICAL SOCIETY POLICY ON VISION TESTING OF SCHOOL CHILDREN

Connecticut has a statute which requires that the vision of all children in the public schools be tested once a year. Such testing has shown vision defects in many children and has frequently revealed the need for a complete professional examination for the first time.

A large scale test of this nature is bound to have the defects of any screening test, namely, unnecessary referrals of normal children (over-referrals) and too few referrals of defective children (under-referrals). Over-referrals disturb the parents because they feel they have been put to an unnecessary expense. Too many under-referrals mean that the test is not accomplishing its objective.

Much optical research and engineering ingenuity have been directed toward creating testing devices. Service clubs have frequently given money to purchase such instruments. Several clinical studies (refs) of testing procedures have been carried out. Various volunteer organizations have assisted in giving the tests. PTA have both enthusiastically endorsed the

program and indignantly objected to the subsequent expense of so-called unnecessary referrals. Perhaps social workers, nurses, and physicians who encounter cases which have been missed by the screening test are most concerned with under-referrals.

School authorities, subject to these conflicting pressures, constantly strive to carry out the statute in the best way possible within the limits of time, personnel, and budget. The State Board of Education, jointly with the State Department of Health, and various local School Boards have sought advice from individual ophthalmologists, from the Eye, Ear, Nose and Throat Section and from the Committee on Eye Care of the State Medical Society.

The resulting study by the medical profession in Connecticut has evolved some conclusions concerning school vision testing which have been approved by the EENT Section and by the Committee on Eye Care. These opinions are now brought to the attention of all physicians in Connecticut with the objective that they become the official policy of the entire State Medical Society.

Approved by House of Delegates, December 6, 1956

CONCLUSIONS

(1) The basic legal requirement is the establishing of the visual acuity on all children in the public schools once a year. This should be extended to include the preschool and the private school groups as well. The basic vision test recommended is reading the Snellen letter or E chart illuminated with 20 foot candles of reflected light at 20 feet.

(2) The standard of vision required for referral should be in conformity with the age of the child. Not every child will have perfect sight, but a high standard will stimulate further search for the cause of the reduced vision. Those children not satisfying the following standards are referred by the school for professional examination:

Preschool children must read 20/40 or better with each eye.

Children in Grades 1, 2, and 3 must read 20/30 or better with each eye.

Children in Grade 4 or higher must read 20/20 or better with each eye. (*Conn. Health Bull.* 67:5; May 1954.)

(3) Elaboration of the basic test by additional tests can only be justified by reducing over- and under-referrals. These additional tests are for the evaluation of near vision, muscle deviation, and depth perception. Extensive surveys (refs) indicate the general conclusion that the more elaborate the procedure and the instrument, the higher the referral rate. This is good in reducing the under-referrals, but it also increases the over-referral rate to an impractical degree. Another objection to elaboration is the false confidence which results from mistaking the screening test for a complete examination. For those schools which have the necessary trained personnel, time, and money for additional tests, the Massachusetts Vision Testing apparatus or its equivalent is suggested:

(a) Near vision: Test for excessive far-sightedness by reading the Snellen chart at 20 feet with + 1.50 glasses.

(b) Muscle deviations: Maddox rod or Dishes test for phorias.

(c) Depth perception: Polaroid vectograph or stethoscope for 3° fusion.

(4) No screening test is completely accurate. Direct observation of the child's eyes and visual behavior, combined with the Snellen Test, is simple, quick, economical and as accurate as any other method. To inform teacher and parent on what to look for, many visual symptoms have been described in layman's terms in the School Referral form now published in Connecticut.

(5) A screening test in no way takes the place of a complete eye examination. To avoid considering the school test as a substitute for a professional exam, professional personnel should not be used to perform the screen test. This confusion would be avoided by a teacher or parent carrying out a simple test. However, it is wise to repeat the screen test, before referral if possible, by a school nurse.

(6) Those children, referred for professional eye examination, must have freedom of choice in the selection of a legally qualified eye examiner. The prerequisite to freedom of choice is to know what the alternatives are. The terms used to describe the various people dealt with are confusing to many people. The broad use of the term "doctor" is another source of confusion. The definitions of ophthalmologists (oculists), optometrists, and opticians incorporated in the School Referral Form should help clarify this confusion.

The new Connecticut "Eye Sight Test Form No. 1," is called "Referral for Eye Examination" and has been published jointly by the State Board of Education and the State Department of Health. It is the outgrowth of the cooperation of many people. The information on this form should prove most helpful to teacher, nurse, and parent. Its simplicity should aid the professional eye examiner. Its use in all schools would result in a uniformity of records, which would aid the school administrator.

The adoption of the Connecticut Eye Sight Test Form No. 1 for use in all school visual screening, its inclusion as a part of the Cumulative Health Record of School Children is hereby recommended.

NEWS FROM WASHINGTON

Health Legislation in 85th Congress

This particular year, two factors of overriding importance should be kept in mind:

First, beyond much question the new Congress, like the last one, will be anxious to vote large sums of money for existing programs, particularly research, and to set up new programs in the health and medical fields. This Congress will not be afraid of spending money or of starting health-medical programs that might be considered experimental.

Second, while the administration may be able to exercise some degree of restraint on Senate and House, the greatest moderating force will be the demands, probably bipartisan, for a stepup in military and foreign aid spending. There can't be unlimited military and foreign aid dollars, and at the same time unlimited health-medical dollars.

As usual, a majority of the health bills won't even be considered seriously by the committees. Some will be the subject of hearings, but not reported out of committee. A few will move on to enactment. However, keep this in mind: All bills not enacted or actually defeated will hold over through 1958 and can be picked up at exactly the point they had reached at adjournment of the 1957 session.

Construction Grants for Medical Schools

The administration again is asking Congress to authorize construction grants for medical, dental, public health and osteopathic schools. The money would be used to help pay for facilities for more students rather than for salaries of teachers or for maintenance costs. The staff of the House Interstate and Foreign Commerce Committee has been gathering data on medical school problems since the last Congress adjourned, and may take up the subject early in this session. The administration sought last year to get a combined bill for grants for building laboratory facilities as well as classrooms, but Congress decided to grant only the former and give the latter more study. The original plan was for an authorization of \$250 million over a 5 year period for both laboratories and classrooms. Congress authorized \$90 million over a 3 year period for laboratories.

Federal Workers Health Insurance

Some of the more optimistic officials concerned with getting a program of contributory, voluntary health insurance underway for federal civilian workers feel it can be accomplished this year. Certainly no single proposal in the health field in recent years has been worked over for so long a period. The goal now is to produce a "package" bill with both basic and catastrophic coverage—one that will meet the approval of the nonprofit plans, the commercial carriers and the federal employees unions. Two previous proposals—one for basic and the other for catastrophic coverage—have failed to pass because of objections of one or more groups to some aspect of the plans.

Voluntary Health Insurance

Both the administration and the Democrats are working on ways to bring about more rapid expansion of health insurance. The administration's reinsurance plan, twice rejected by Congress, remains in the background. Coming to the fore this year is a substitute plan which would permit smaller insurance companies (the larger ones say they don't need it) to pool their resources without violating anti-trust laws. It is felt this would stimulate coverage for major medical expense, for farmers, for the aged and for low income families. The plan was introduced last session but too late for hearings.

A liberal Democratic favorite in this field is the plan for federal grants to States to help them establish new health plans or assist existing plans. Under it, persons would purchase health insurance with premiums scaled according to their income. The indigent would receive the insurance without cost. This proposal is certain to be pushed in the 85th Congress.

Any legislation that results could combine some of the features of the three different approaches under study.

Tax Deferral on Retirement Plans

Interest has been revived in the Jenkins-Keogh plan for permitting the self employed to defer

payment of taxes on money paid into retirement plans. The American Bar Association is pushing for enactment of a bill this session, and has reported that more than half of the members of the House favor the principle of tax deferment for self employed. Supporters of the proposal (which include the American Medical Association) point out that enactment of the plan would place professional groups on a par with employed persons. Industry now is permitted to deduct money paid into annuities.

The cost of this proposal will be one of the points on which it will be vigorously attacked. Both the administration and the Democrats are opposed to any legislation that would reduce tax income and unbalance the budget.

Rep. Eugene Keogh (D., N. Y.) introduced a new version of the proposal when the session began on January 3. One suggestion is that a person, on payment of a tax penalty, be permitted to make withdrawals from his retirement fund before age 65. The American Medical Association has supported Jenkins-Keogh type bills since 1948 in the belief that the self employed are now discriminated against. Tax laws permit employers to set aside limited sums of money for their employees on a deferred tax basis but this is denied the self employed.

Keogh-Jenkins (HR9 and 10), new style, provides for a \$5,000 maximum set aside annually for retirement, compared with \$7,500 in bill of last year. Slightly higher deductions are authorized for persons past age 50. It was age 55 in former bill. A number of other changes have been made. Congressmen are waking up to increasing demand for a tax-relief bill of this kind.

Miscellaneous Legislation

Many other measures bearing on the medical profession will again come up in the 85th Congress. Among these will be:

POLIO-MYELITIS VACCINE GRANTS ACT

Congress will have to decide before next July 1 whether, in the light of a great backlog of supplies, to extend the law which gives the States money to help them in free vaccine programs against polio-myelitis. The administration has been urging the

public to take inoculations now, in view of the oversupply of vaccine.

BRICKER AMENDMENT

Senator Bricker (R., Ohio) again plans to sponsor a version of his proposed amendment to the Constitution to prevent enactment of domestic law through treaty or executive agreements.

LOCAL PUBLIC HEALTH UNITS

More activity may be expected on federal aid to local public health units, a proposal that failed of passage several years ago when Congress could not agree on the definition of what is public health.

NURSING SCHOOL AID

Similarly, bills on federal grants for building nursing schools are expected, as well as on funds for maintenance and scholarships.

OTHER BILLS INTRODUCED

Rep. Kenneth B. Keating (R., New York) again has filed his bill (HR286) permitting tax deductibility of premiums paid into health insurance plans. A few of the other carry-overs from 84th Congress are Thompson bill (HR489) on aid to voluntary prepayment plans; the Judd bill (HR246) on Indian public health measures, and miscellaneous bills on benefits for the aging and liberalization of veterans' medical care privileges.

Tax Ruling Favorable to Health Insurance Issued

A tax ruling published recently (December 10 Internal Revenue Bulletin) ought to promote expansion of contributory medical care insurance in business and industry. Case at issue: Whether premiums paid by an employer to provide hospitalization and surgical coverage to workers ineligible for inclusion in an insurance plan offered to union member employees are (1) deductible as an ordinary and necessary business expense, and (2) includible as employee income.

Internal Revenue Service held that the arrangement for nonunion employees in a firm's payroll constitutes a plan within meaning of Sec. 106 of Revenue Code; that employer's premium payments are not subject to withholding tax because they are not income, and that expenditures for premiums are properly deductible as business expenses.



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Physician Members of 85th Congress, Which Convened in January

Walter H. Judd of Minnesota, member of House since 1942. Served in field artillery in World War I, medical missionary in China 1925-31 and 1934-38; just prior to World War II staged virtually one-man campaign to arouse people of U. S. against Japanese military expansion. Arthur L. Miller of Nebraska, member of House since 1942. Army reserve surgeon in World War I, Mayor of Kimball, Nebraska, member Nebraska legislature, State health director. Ivor D. Fenton of Pennsylvania, member of the House since 1939. Army surgeon for 20 months in World War I, 11 months overseas. Thomas F. Morgan of Pennsylvania, member of House since 1944. Maintains practice at Fredericktown, Pennsylvania. Will E. Neal of West Virginia, member of House 1952-54, elected again for 1957-58. General practice at Huntington, West Virginia, since 1906, with exception three years as mayor. Served in State legislature and in various health posts. Antonio Fernos-Isern, Puerto Rico's Resident Commissioner in Washington since 1946. Cardiologist, professor of public health in School of Tropical Medicine of Puerto Rico, commissioner of health, and acting governor of the island several times prior to election to House.

TOTAL REPRESENTATION

Six physicians now are members of the House of Representatives of the 85th Congress that convened in January. Counting them, a total of 359 physicians have served in American Congresses since 1775, including 35 Senators. Of the 359, eleven practiced another profession—generally law—as well as medicine, 33 were not active in practice when elected, and 18 had graduated in medicine but never practiced.

BY PARTIES

A total of 165 physicians were Democrats. Other party representation: Republicans 67, Whigs 30, Federalists 17, Jacksonian Democrats 6, American party 5, National Republicans 2, Independents 2, and one each from six other minor parties. There is no record of party affiliation for 32 doctors in Congress, and party labels were not attached to the 27 who sat in the Continental Congress between 1775 and 1788.

BY STATES

The large States that were members of the original 13 Colonies naturally have supplied the most doc-

tors to Congress. Connecticut has elected six to Congress.

Physicians' Committees Considered in Disability Program

A recommendation of the Indiana State Medical Association is under consideration by the Social Security Administration. It would establish district or county committees of physicians to review individual doctors' medical findings under the new law providing O.A.S.I. payments to disabled at age 50. The committee would review the physician's report, further examine the applicant if it so desired, and be authorized to file the final report of impairment determination and make recommendations as to whether the report might be reversible by medical or other rehabilitative measures. In presenting the proposal to the Social Security Administration, the Indiana society declared that its plan would (a) afford an unbiased medical review of the case, (b) remove family and possibly political pressure from the physician, and (c) provide the State agency with a more factual and comprehensive report than it would otherwise obtain, "which should be of great assistance in making the final determinations as to disability payments." Social Security Administration has not yet decided whether to adopt the procedure, but has it under study. A similar recommendation (Res. No. 25) is under study by the AMA Board of Trustees.

Rusk Committee Urges Integration of Hungarian Physicians

The Health Resources Advisory Committee of the Office of Defense Mobilization, under chairmanship of Dr. Howard Rusk, is asking all health and educational institutions and organizations to "make every effort" to assist in the re-establishment in this country of Hungarian physicians, dentists, medical and dental students and other health personnel now coming in as refugees. This committee advises the director of ODM on problems relating to supply of health personnel. The committee approved the following resolution:

"The health professions like all other Americans have been deeply shocked by recent events in Hungary. The professional integration of these new Americans who are physicians, dentists, medical and dental students and other health personnel into American health agencies, both private and public,

medical and dental schools, and other health educational programs, will pose many difficult problems. The Health Resources Advisory Committee, however, earnestly urges every American health organization and educational institution to make every effort to lend its aid and resources toward the re-establishment of our new professional colleagues in situations commensurate with their professional status. With our national shortage of health personnel of all types, these new Americans can make a distinct contribution to our health resources. To the dignity of political and personal freedom let us help give them the dignity of professional status."

Two HEW Posts Filled by Eisenhower; Other Jobs Pending

A Philadelphia pediatrician and a Boston attorney have been named by President Eisenhower to key posts in the Department of Health, Education, and Welfare. They are Dr. Aims C. McGuinness, who succeeds Dr. Lowell T. Coggeshall as special assistant to the secretary for health and medical affairs, and Elliot L. Richardson, who becomes assistant secretary of HEW, succeeding Roswell B. Perkins.

Dr. McGuinness for more than a year was clinical consultant to the United Mine Workers Welfare and Retirement Fund, and was responsible for the medical staffing of the fund's 10 hospitals. Prior to that, he was dean of the University of Pennsylvania Graduate School of Medicine. He was director of the Children's Hospital of Philadelphia from 1948-51. Dr. McGuinness was educated at Princeton, and received his medical degree from Columbia. In World War II he served in the Army.

Mr. Richardson has been an HEW consultant for several months. In his new post he will assist in the development and coordination of programs, particularly legislative. At the time of his appointment he was with a Boston law firm. He has served as consultant to Gov. Christian Herter, as assistant to Senator Saltonstall (R., Massachusetts), and as law clerk to Judge Learned Hand and to Supreme Court Justice Felix Frankfurter. Posts still unfilled in HEW are chief of the Children's Bureau and another assistant secretary. Under Secretary Herold C. Hunt will resign soon.

Administration Announces Medical- Welfare Aims

As Congress opened, the Eisenhower Administration, through Secretary Folsom, announced part of

its medical-welfare program for this year. The major points are: 1. A new law to authorize \$250 million in grants (over five years) to help pay for new construction and equipment for medical, dental, and public health schools. 2. Stepping up the federal-state rehabilitation program along three lines—more special project grants (where U. S. pays full cost), increased efforts for the professional training of more rehabilitation workers, and "strong assistance" to States so they can extend and improve their own rehabilitation operations. 3. More effort and money for Indian health care, including a request for Congress (turned down last session) for \$29 million for sanitary facilities. 4. More attention to research in the basic causes of poverty and dependency, and more State grants to help in professional training of social workers.

THE DOCTOR'S OFFICE

Henry B. C. Low, M.D. announces the opening of an office for the practice of surgery at 80 Seymour Street, Hartford.

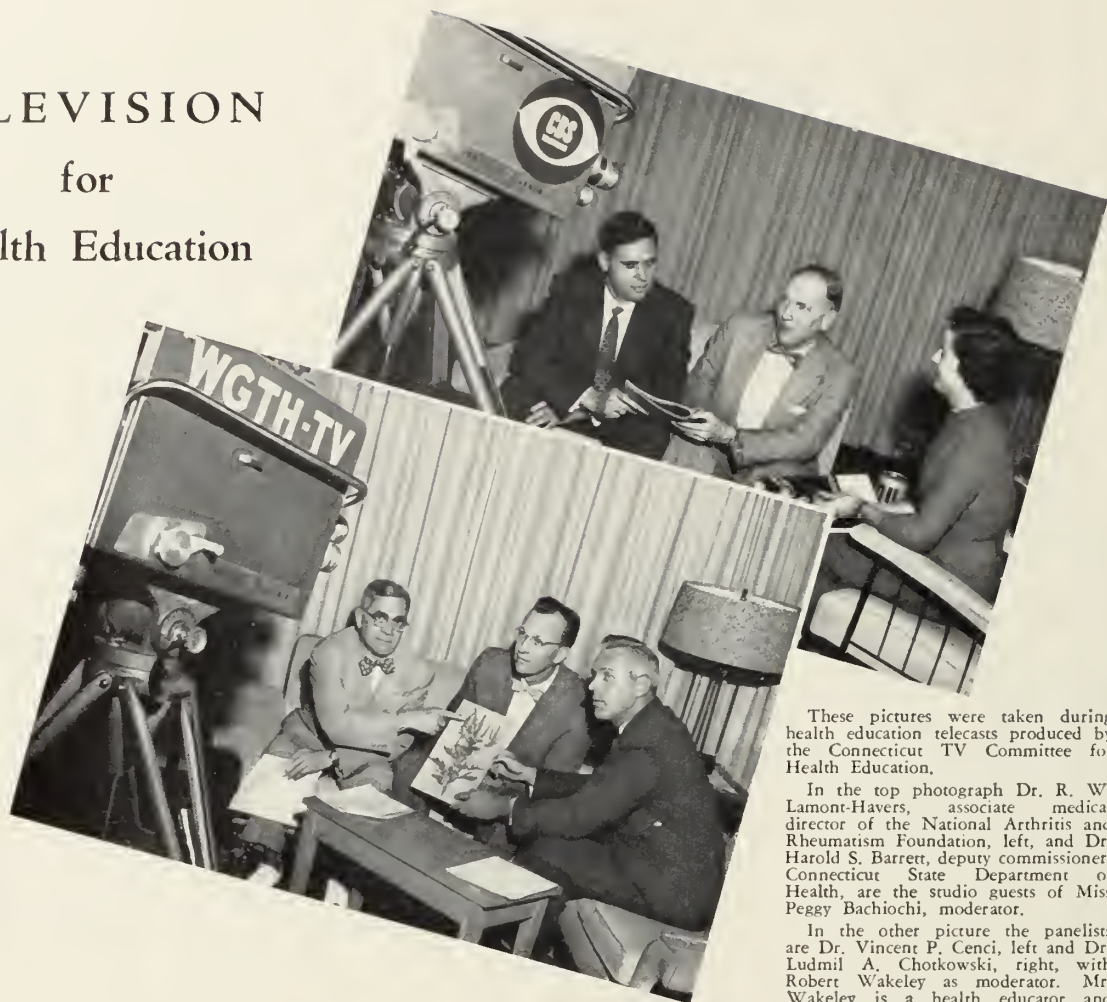
Charles E. McLean, M.D. has closed his office to the practice of cardiology and is now full-time director of the Cardio-Respiratory Laboratory at the Hartford Hospital. He will continue to be available for consultations through the Hartford Hospital.

Southern Medical Association 50 Years Old

In October, 1956 the Southern Medical Association celebrated its golden anniversary at the Read House in Chattanooga, Tennessee where it first met in 1906. *The Southern Medical Journal* in November, 1956 carried an account of the anniversary under the heading, "The Birthday Story 1906-1956." Beside giving the detailed program of the celebration, it contained a brief historical sketch of the Association together with a list of those who attended the first meeting 50 years ago. Historical addresses were delivered, greetings were exchanged, Golden Anniversary Keys were presented, and plaques from the Woman's Auxiliary to the Southern Medical Association and from the latter to the Read House were given.

Our Dixie friends had a great time. They are fine gentlemen. We congratulate them.

TELEVISION for Health Education



These pictures were taken during health education telecasts produced by the Connecticut TV Committee for Health Education.

In the top photograph Dr. R. W. Lamont-Havers, associate medical director of the National Arthritis and Rheumatism Foundation, left, and Dr. Harold S. Barrett, deputy commissioner, Connecticut State Department of Health, are the studio guests of Miss Peggy Bachiochi, moderator.

In the other picture the panelists are Dr. Vincent P. Cenci, left and Dr. Ludmil A. Chotkowski, right, with Robert Wakeley as moderator. Mr. Wakeley is a health educator and member of the staff of the Connecticut Division, American Cancer Society. Miss Bachiochi is a staff member of the Connecticut Chapter, Arthritis and Rheumatism Foundation.

The Connecticut TV Committee for Health Education, now in its third year of operation, comprises representatives from 15 statewide health agencies and four television stations. The purpose of the committee is to provide authentic and useful health education programs in cooperation with television stations as a public service.

The Committee is producing two series this year, "Accent on Living" WHTC-TV, Hartford each Saturday 1:30-2:00 P. M. and "Stay Well," WNBC-TV, New Britain, each Thursday, 1:15-1:30 P. M.

Member organizations of the committee are the Connecticut State Medical Society; Connecticut State Department of Health; Connecticut Association for Mental Health; Connecticut Hospital Association; Connecticut Division, American Cancer Society; Connecticut State Department of Mental Health; Connecticut Chapter, Arthritis and Rheumatism Foundation; Connecticut State Commission on Alcoholism; Connecticut Heart Association; Connecticut League for Nursing; Connecticut Society for Crippled Children and Adults; Connecticut Tuberculosis Association; Connecticut State Tuberculosis Commission; Connecticut Chapter, National Society for the Prevention of Blindness; and the Connecticut Association of Sanitarians.

PUBLIC RELATIONS

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Fairfield County Medical Association Participates in Career Day Program

The Fairfield County Medical Association and the Bridgeport Medical Association recently completed participation in a Career Day Program for high school students sponsored by the Bridgeport Chamber of Commerce.

The project comprised a one month series of speaking programs by physicians, dentists and attorneys and representatives from business and industry. The programs were presented for junior and senior high school students in all of the secondary schools in the Bridgeport area.

Medical Horizons Announces 1957 Series

The national television series, "Medical Horizons," which has been cited by the American Medical Association for service to the medical profession, will present 34 programs from sites in all parts of the country during 1957.

The series, now in its second year, will continue to present live documentary reports on new developments in medical science to a national television audience each Sunday at 4:30 P. M. (E.S.T.).

The project is sponsored by Ciba Pharmaceutical Products and institutions where programs are scheduled for the current series include Johns Hopkins University; the Mayo Clinic; Meharry Medical College; School of Medicine of the University of California, San Francisco; and Georgetown University.

National Survey on Medical Meeting Attendance

A recent national survey of attendance at medical association meetings indicates that 50 per cent of physicians attend most meetings of their local and county societies.

The survey was conducted by the American

Medical Association and cited regional differences in attendance. It was indicated that in the East approximately 38 per cent of members attend association meetings, while Western States claim attendance of more than 60 per cent. Central and Southern States rank midway in attendance, with 54 per cent in the Midwest and 56 per cent in the South.

Two New Films Released for Local Medical Groups

"Even for One," a new television film produced by the American Medical Association, was released February 1 for use by local medical associations.

The film portrays the personal qualities of a participating physician and the value of his judgment. The story concerns a general practitioner and the family problems he encounters in treating a boy's illness.

Medical societies are being urged by the AMA to make arrangements with local television stations for scheduling the film. Prints for specific booking dates may be obtained from the Film Library, AMA.

Also released for use at medical association meetings is the first film in a series "Medicine and the Law." This was produced for the AMA in cooperation with the American Bar Association.

The film is now available to local medical groups through the AMA's Film Library. The 30 minute production, captioned "Doctor Take the Stand," shows what procedures to follow when testifying in court.

Medical Films Viewed by Connecticut Audiences

The 16 mm. film, "A Life to Save," was recently televised from the studios of WICC-TV, Bridgeport to an estimated audience of more than 50,000 viewers. The AMA film also has been viewed recently

by more than 300 Connecticut industrial employees and members of educational groups.

Two other films, "Your Doctor" and "Operation Herbert," were showed to more than 1,000 high school students and members of community organizations in Norwalk, Stratford, Bridgeport and Hartford.

Nearly 16,000 Attacked by Polio in 1956

During 1956 polio struck down nearly 16,000 persons. This was a 45 per cent decrease from the 1955 total and a 58 per cent decline from the 1951-55 average. It was the lowest number of cases recorded since 1947.

The picture as it emerged during 1956 showed that paralytic polio struck far more often against the unvaccinated than those who had received one or more shots. California, for example, which led the nation with a total of more than 2,100 cases, reported that about 90 per cent of those stricken with paralytic polio were unvaccinated. In Minnesota, two shots of vaccine were 77 per cent effective against paralytic polio during the 12 months ended October 31, 1956.

Although the reductions were gratifying polio still proved it packed a deadly epidemic punch. In the Chicago polio epidemic 1,080 persons were stricken up to October 30, and 36 died. But for the Salk vaccine the epidemic might have been worse. Chicago's Board of Health officials said the vaccine had "broken the back of the epidemic." Of the total victims 681—more than three out of five—were paralytic. Of these, 154 had received one shot of vaccine, 57 had received two shots and none had the protection of the full three-shot series.

Statement on Hoxsey Cancer Treatment

GEORGE P. LARRICK

U. S. Commissioner of Food and Drugs

For the second time a Federal court has determined that the Hoxsey medicines for internal cancer are worthless. On November 15, 1956, after a six-week trial in the Federal court at Pittsburgh, the jury returned a verdict that these medicines, in pill form, were illegally offered as an effective treatment for cancer. On November 16, U. S. Dis-

trict Judge John L. Miller signed an order of condemnation stating that the pills were misbranded as charged by the Government and ordering their destruction.

The public should know, however, that this action does not end the menace of this fake treatment. It merely means that half a million of the Hoxsey pills, which were seized shortly after the opening of a second Hoxsey Clinic at Portage, Pennsylvania, will now be destroyed. An injunction is being sought to stop further interstate shipment of the pills. We intend to use every legal means within our power to protect consumers from being victimized by this worthless treatment.

In the meantime it is of the utmost importance that cancer patients and their families, who may be planning to try the Hoxsey treatment either at Dallas, Texas, or Portage, Pennsylvania, should acquaint themselves with the facts about it. All such persons are advised to secure a copy of the Public Warning which was issued by the Food and Drug Administration last April. They may do this by writing to the Food and Drug Administration, Washington 25, D. C.

Harry M. Hoxsey has continued to promote his worthless cure for more than 30 years, notwithstanding numerous local and state court actions. Proceedings under the Federal Food, Drug, and Cosmetic Act did not appear possible until a 1948 decision of the Supreme Court interpreting the word "accompanying" in the definition of labeling under the Act. An injunction suit was filed in 1950 and a decree finally issued by the Federal court at Dallas in 1953.

Over the years thousands of persons have been deceived by the false claims for the Hoxsey liquid medicines and pills. At the Pittsburgh trial there was testimony concerning persons who may have died of cancer as a result of reliance on the Hoxsey treatment instead of seeking competent medical treatment in the early stages of their condition. The Government's evidence showed that alleged "cured cases" presented by defense attorneys were people who either did not have cancer, or who were adequately treated before they went to the Hoxsey Clinic, or who died of cancer after they had been treated there.

OUR MEDICAL WORLD

The New Look in Scientific Research in the Soviet Union

We are indebted to R. E. Marshak, Harris professor of physics at the University of Rochester, for some interesting observations on the changes that have taken place in the Soviet Union since Stalin's death, particularly as they bear on scientific research.* He lists the following:

- 1. It seems that all scientists who were formerly in disgrace or under arrest have been rehabilitated and that all the brilliant scientists who had been in trouble have been returned to positions of leadership.
- 2. All the usual scientific channels of communication are now open, including the exchange of scientific and technical information with foreign scientists.
- 3. Personal contact with foreign scientists is now allowed.
- 4. The rigid mobilization of Soviet scientists to work on war projects has apparently been discontinued.
- 5. A much more liberal policy of declassification of scientific research has been adopted.
- 6. Soviet science is much less nationalistic now than it was in the Stalin era.
- 7. There has been a considerable devaluation of Marx's philosophy insofar as pure science is concerned.
- 8. Freedom of criticism in science is accepted as a virtue.

The author points out that the re-emergence of scientific freedom is not to be confused with political freedom where there has been some slight improvement in the Soviet Union but in which there is still a long way to go. This new look should portend a better day for medical research and hence for Soviet medicine for original research can prosper only in an atmosphere of freedom.

British Medical System

Johnson of Rockford, Illinois, after observing for three months some plastic surgical centers in Eng-

land, writes in the November issue of the *Illinois Medical Journal* that the British system of medicine would be a fiasco if transplanted in America because of the basic differences of economy and culture. All political parties in England have committed themselves to some form of State medicine. The author warns us that we must choose our leaders in American medicine with care lest such a thing happen to us.

Protection of Civilian Doctors

In activities to fulfill its objectives "to maintain the honour and protect the interests of the medical profession" and "to assist all peoples of the world to attain the highest possible level of health." The World Medical Association has adopted an emblem to be used by civilian doctors, their ancillaries and civil defense installations.

Studies of the 4th Geneva Conventions and Conferences with representatives of the International Committee of the Red Cross revealed that the protection of the Red Cross Emblem did not and could not apply except to doctors, ancillaries and medical installations in military organizations. Hence, in time of war, the civilian doctor, his assistants and civil defense units not under military control were without protection in carrying out their humanitarian responsibilities to the population.

The World Medical Association has adopted a medical emblem and a Code of Medical Ethics in time of war. These were recommended by a joint Committee made up of representatives of the International Committee of the Red Cross; the International Committee on Military Medicine and Pharmacy and The World Medical Association with the World Health Organization providing an observer. Adoption by the member associations and legislative enactments in each country and recognition at the international level to insure complete protection under the emblem is now being implemented.

THE MEDICAL EMBLEM

The new medical emblem destined to protect civilian doctors, their ancillaries and civilian defense units is a red staff and serpent upon a white field.

*Science, 124:3232, December 7, 1956
February, 1957

The staff is represented by a vertical line; the serpent by a sinuous line over the vertical line with two (2) undulations on the left side and one (1) undulation on the right side.

MEDICAL ETHICS IN TIME OF WAR

"Medical ethics in time of war is identical with medical ethics in time of peace, as established in the International Code of Medical Ethics of The World Medical Association. The primary obligation of the doctor is his professional duty; in performing his professional duty, the doctor's supreme guide in his conscience!"

Subsequent statements in this Code provide:

The primary task of the medical profession is to preserve health and save life;

The doctor, in emergencies, must always give the required care impartially and without consideration of sex, race, nationality, religion, political affiliation or any other criterion and will continue this medical assistance as long as necessary;

All treatment given by the doctor must be in the best interest of the patient;

Scientific knowledge may never be employed to imperil health or destroy life;

Medical secrecy must be preserved; and

The privileges and facilities afforded the doctor must never be used for other than professional purposes.

To the Aid of Hungarian Physicians

It must be heartening to the physicians in Connecticut to learn of all that is being done to aid the physicians of Hungary who escaped with their lives from the Hungarian Secret Police. On December 19, 1956 a release was issued by the Secretary General of the World Medical Association, Louis H. Bauer, to the effect that the Hungarian Secret Police had been arresting all doctors in Hungary who treated injured revolutionaries and failed to report their services as required by law. Dr. Bauer appealed to physician members of its United States Committee for employment opportunities for medically qualified refugees, and also to corporate members of the U. S. Committee for advice on employment opportunities, and positions which might be available to these medical refugees.

Two days later George F. Lull, secretary and general manager of the American Medical Association, in his letter to member physicians recounted

the story of a 36 year old urologist and his wife, a 30 year old pediatrician, and their small son who were among 72 Hungarian refugees to reach Chicago the middle of December under the sponsorship of Cardinal Stritch. Here is their story:

The two physicians, Laszlo and Elizabeth, who could speak some English, left Budapest on November 22 and arrived in Chicago three weeks later to the day. But the intervening three weeks were a nightmare.

Both were graduated from Budapest University and both were professors at the medical school. He served as a urological surgeon for 12 years; she as a pediatrician for six years.

In company with an agricultural professor from the same university, his wife and two boys, the two doctors and their baby set out for the Austrian border, 200 miles away, in a milk truck. The friendly driver took them to within a few miles of the border. The party walked less than a mile when they were captured by secret police guards and their real troubles began. They were taken to a barn where 60 other refugees were interned; they were kept there for two days and nights. There were no facilities of any kind, only trampled straw on the floor. A friend recognized the agricultural professor and his family and somehow managed to engineer their escape under the cover of darkness. The two doctors never saw their friends again after that night.

On the morning of the third day all of the refugees, including Laszlo and his wife, were herded into a truck which was to take them to a larger and more permanent Russian prison camp. As the truck was being unloaded near the camp, one of the refugees bolted and ran. The two guards took out after him and when they did the other refugees ran wildly in every direction—across fields, down roads and through woods.

"We ran and when we were tired we ran some more," said Dr. Elizabeth. She and her husband and the baby were befriended by a doctor they knew in a nearby city. He put them aboard a bus with other refugees heading for the border.

"The bus driver let us out at the border, but we soon learned that we still had a quarter of a mile to go," Dr. Elizabeth said. "We never knew when we actually crossed the border. We put the baby to sleep and walked and ran for three hours in the dark, always fearful that we might be going the wrong

(Continued on page 156)

OBITUARIES

George Adelor Gosselin, M.D.

1889 - 1956



Dr. George Adelor Gosselin died suddenly at his home in West Hartford on November 25, 1956. He was born in Rutland, Vermont, February 1, 1889 and received his B.A. degree from Laval University, Quebec, Canada, and his M.D. degree from Vermont College of Medicine.

From 1920 to 1921 Dr. Gosselin studied neurology and psychiatry in Paris, France and subsequently became a member of the staff at the New York Neurological Institute, a position he held until the time of his death. Since 1926 he had been an adjunct attending neurologist. He had been consultant to several hospitals in the Hartford area and was attending neuropsychiatrist at St. Francis Hospital. He had practiced in Hartford nearly 35 years and for some time had offices in Bristol and Waterbury. During World War I, Dr. Gosselin served as a Lieutenant in the Medical Corps, U. S. Army.

Dr. Gosselin was a member of the American Medical Association, the Hartford Medical Society, the American Board of Neurology and Psychiatry, and was at one time president of the Connecticut Psychiatric Association.

To his colleagues who knew him well Dr. Gosselin had not only diagnostic skill but also broad knowledge of the practicable and valuable in the field of therapy. He had the esteem and respect of his fellow physicians and patients.

Dr. Gosselin leaves his wife, Mrs. Edith Nelson Gosselin; a son, John N. Gosselin; a daughter, Elizabeth A. Gosselin, and a sister, Mrs. O. G. Chamberland, of Rutland, Vermont.

Arthur B. Landry, M.D.

William T. Nagle, M.D.

1892 - 1956



Following an illness of several months Dr. William T. Nagle died on July 17, 1956 in his 64th year. The son of the late Mr. and Mrs. William C. Nagle, he was a lifelong resident of Southington, Connecticut.

Dr. Nagle received his preliminary education in the local public schools. He was graduated from the University of Pennsylvania Medical School in 1915. He served his internship at Saint Raphael's Hospital in New Haven, Connecticut. In 1916 he opened his office for the general practice of medicine in Fairfield.

Enlisting in the United States Army in 1917 Dr. Nagle was attached to the Yankee Division as field surgeon. After being severely wounded on the battlefield in France he received the Purple Heart Decoration.

Upon his discharge he reopened his office for the general practice of medicine in Hartford, Connecticut, where he remained one year. He then returned to Southington, where he maintained his practice until his death. He served as medical examiner for the town for several years. Since 1945 he was associated with the Veteran's Administration of Newington as local examiner.

Dr. Nagle maintained active membership in the American Medical Association, Connecticut State Medical Society, and the local Southington Medical Association of which he served as president for three terms. His activities in veteran's affairs included membership in the American Legion and the Veterans of Foreign Wars.

A deeply religious man, William Nagle was a member of Isabella Council, Knights of Columbus and the Fourth Degree Assembly. He was married to the former Rhetta Hurley and had two children, Rev. Father William Nagle of Fairfield, Connecticut and Mrs. Robert Stanton of Southington, Connecticut.

Dr. Nagle will be remembered by all his associates in and out of his profession for his quiet unassuming manner, his deep regard for his fellowman and his great devotion to his God and his family.

Thomas W. Dudac, M.D.

OUR NEIGHBORS

Maine

John R. Lincoln, anesthesiologist at the Maine General Hospital, Portland, has been elected to a six year term as a member of the Board of Governors of the American College of Anesthesiologists. Dr. Lincoln served an internship at the Hartford Hospital and later a residency there under Dr. Ralph M. Tovell.

Memory of Dr. Beaumont Honored

For the 103rd time the St. Louis Medical Society made a pilgrimage recently to the grave of Connecticut-born William Beaumont on the anniversary of his death. Dr. Beaumont was the third president of the St. Louis Society.

Ten Years of Service

Ten years ago the first Connecticut Cancer Conference for physicians was held in New Haven. Two hundred physicians from everywhere in the State attended that first conference, one of the earliest of its kind in the United States.

The conference has been held annually since that time in either Hartford or New Haven with attendance increasing to as many as 450 physicians. This year the conference is to be held Wednesday, March 13, at the Statler Hotel in Hartford.

The State Medical Society, the Connecticut State Department of Health and the Association of Connecticut Tumor Clinics have joined with the Connecticut Division of the American Cancer Society in sponsoring this postgraduate conference each year. It should be a source of pride to each organization that the conference is now in the tenth year of successful operation.

The chairmen and members of the various subcommittees of the Society's Committee on Post-Graduate Education deserve the praise of every practicing physician for the excellent programs they have continued to produce and which form the root of conference success. These have been consistently planned to benefit physicians in general practice and several years ago were approved for postgraduate credit by the American Academy of General Practice.

Dr. Bernard F. Mann, Jr., New Haven, chairman of the program committee this year, has announced an outstanding symposium on intra-oral and pharyngeal neoplasms as the main accent of the 1957 conference and the program is published elsewhere in this issue of the JOURNAL.

Certainly no greater challenge faces medicine today than the early diagnosis and treatment of this disease and discovery of its etiology and prevention. Every practicing physician who attends the March conference will be helping to meet that challenge in increased measure.

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., C.P.H., Commissioner

TPCF (*TREPONEMA PALLIDUM* COMPLEMENT FIXATION) TEST NOW AVAILABLE

EARLE K. BORMAN, M.S., *Hartford*

The Author. *Section Chief, Laboratories Services*

THE Laboratory Services Section of the Connecticut State Department of Health is prepared to accept blood specimens for the TPCF (*Treponema pallidum* complement fixation) test for indication of syphilitic infection.

The TPCF is not a replacement for the routine standard tests for syphilis but is offered as an additional aid to physicians in resolving diagnostic problems that arise when clinical evidence is inconclusive or is not compatible with the laboratory findings by the standard tests. The cost of the antigen prohibits at the present time the performance of the test on a routine basis.

Specimens for the TPCF test will be accepted for examination only under the following circumstances:

1. Diagnostic problem cases.
 - a. Standard tests for syphilis have been reactive on at least two separate specimens and
 - b. Clinical evidence or history of syphilis is absent, inconclusive or not compatible with the laboratory findings.
2. Pregnancy problem cases.
 - a. Previous standard tests for syphilis have been reactive in the absence of clinical evidence of infection and
 - b. The need for diagnosis and possible treatment is urgent.
3. Miscellaneous problem cases.
 - a. Standard tests for syphilis have been reactive or nonreactive and
 - b. Patient is hospitalized in a mental or state institution, the diagnosis is inconclusive and a specific need exists for ruling out syphilitic infection.

or

An unusual diagnostic problem is evident and requires confirmation with the TPCF test.

Blood specimens for TPCF tests may be submitted in the special outfit marked with the code letters TP obtainable on request. At least 10 ml. of blood is required and each specimen must be accompanied by the findings for previous standard tests for syphilis performed for the patient and a short clinical history indicating the reasons for requesting the TPCF test. The history slip included in the TP collection outfit indicates the information required and must be returned to the laboratory in completed form with the specimen.

The TPCF test utilizes an antigen prepared from an extract of *Treponema pallidum* organisms and detects an antibody distinct from the reagin of the standard tests for syphilis. Preliminary studies show close correlation of the findings with those of the *Treponema pallidum* Immobilization (TPI) test; however, the TPCF appears to be more sensitive than the TPI in detecting primary and secondary syphilis and less sensitive in latent and late syphilis.

The standard tests for syphilis are useful and reliable for detecting cases and controlling treatment except for a small percentage of examinations when "biologic false positive" reactions are suspected. The majority of biologic false positives usually are eliminated by repeat specimens. The technical false positives may be eliminated with the second specimen and the transitory false positives ordinarily revert to negative within three months. The remaining persistent reactors without clinical evidence of syphilis become diagnostic problems and even experienced syphilologists may have difficulty differentiating between the latest syphilitic and the chronic BFP. The newer treponemal tests have been helpful in resolving this type of diagnostic problem and are

reassuring in a few other instances, such as pregnancies, when the possible necessity for treatment is urgent and there is not time to wait for false positive STS to recede spontaneously.

Although the TPCF and the TPI tests have become important additional aids to physicians in resolving some diagnostic problems, they must be interpreted with caution. Neither test provides a final answer to all the diagnostic problems arising when laboratory findings are not compatible with clinical evidence. The STS still remain the most useful aids to physicians for controlling treatment.

HUNGARIAN PHYSICIANS

(Concluded from page 152)

way. Finally we spotted the Austrian watch tower and knew we were safe.

"The baby came through the rough trip quite well, except for a large lacerated swelling on the right temple. This was caused by the jostling he got when we were running and stumbling toward our destination. The baby apparently lay in one position and its head rubbed against the basket for quite some time."

"Have you ever heard of the American Medical Association; do you know anything about the organization?" Dr. Laszlo was asked.

"Of course," he said, adding: "We were well acquainted with your publications while we were at the University, but the name meant much more to us when we reached a refugee physician processing center in Vienna. It was there that we received 500 shillings (\$20) apiece and we will be forever grateful. They told us the money represented contributions from several medical organizations and they mentioned the American Medical Association.

"Hungarian medicine today is—to use an American expression—in a mess. The urological staff at the university hospital consisted of 20 physicians. On the day we left there were only three and one of them was an old physician who was ill, leaving only two.

"The revolution," he continued, "was started by students. Since we were on the teaching staff, the Russian masters hold all teachers responsible. Even before we left, a general housecleaning of the teaching staff was started. Teachers are being substituted by party followers who can be trusted with indoctrinating the youth in Russian ideologies and practices.

"Neither my wife nor I were members of the party. That is why we were never able to get on the clinical staff of the university. Our jobs carried a great deal of prestige, but little salary."

Dr. Laszlo said that the medical university curriculum is being filled, more and more, with military subjects, socialist theory, and the Russian language.

"A great amount of time is being spent on non-professional studies," he said.

Dr. Laszlo and his wife have no immediate plans for the future except that both want to study and speak English as soon as possible. They both know that it is a basic requirement for licensure.

"We realize we have many problems in a new and strange land," he said with a wave of his hand. "Our most immediate is to find a way of earning a livelihood until that day when we can carry a little black bag and care for our own patients. Freedom to work and study and pray is what we dreamed about and now that we are in America little else matters."

Our own State Society secretary has issued a statement to the effect that his office is ready to assist in placing any refugee physicians from Hungary that they may earn a living and prepare themselves for citizenship in the United States. Thus we find the true spirit of the Great Physician exemplified in this time of need at our very doors.

New England Postgraduate Assembly

The annual report of the New England Postgraduate Assembly is not too heartening. The Assembly met for three days in October and November 1956 and while it showed a profit of \$4,000 which was due in part to an increase in income from exhibitors, the total number of physicians attending was less than any previous year except 1951. A reduction in the number of formal lectures and an increase in the number of panels and symposia was a feature of this year's program. An innovation entitled "Curbstone Consultations" was offered at lunch as an alternative to the luncheon panel.

The total registration was 592 physicians and 131 others, including interns, residents, students, fellows and guests. Connecticut registered 41 of whom two were speakers, one as a Committee member was chairman of a morning session, and three were residents.

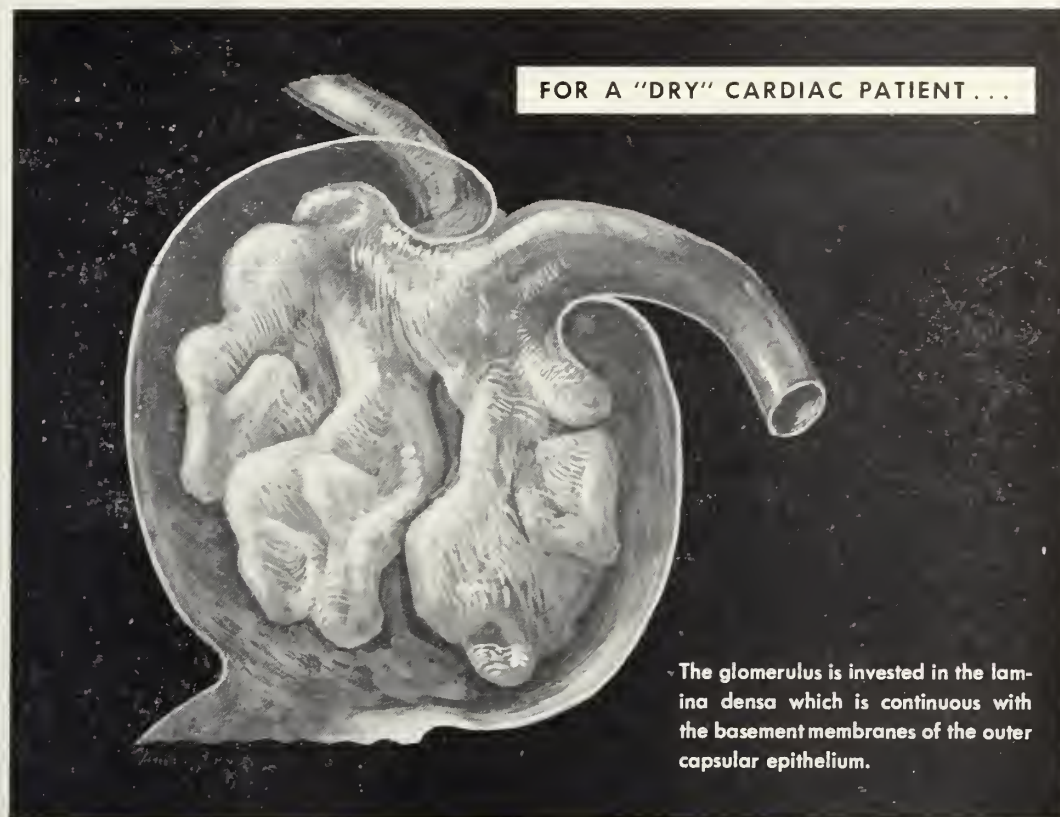


Illustration by Hans Elias

Rolicton® Diuresis Maintains Continuous Edema Control

The efficacy of Rolicton (brand of amiso-metradine) in maintaining diuresis in the edematous patient has been established on an average dosage of one tablet b.i.d. Larger doses may be given as initial therapy and as maintenance therapy in edema difficult to control. Many patients will respond to one tablet daily.

"The margin of safety and the diuretic index is certainly an improvement over the use of oral mercurial diuretics."¹

Avoiding "Peaks and Valleys"

A highly desirable effect, and one which has been made possible with Rolicton, is the maintenance of continuous diuretic effectiveness day after day over an extended period, to avoid the up-and-down weight pattern typical of other edema-control methods.

"There was an obvious stabilization of weight in practically all of the patients under observation, and previous wide fluctuations in poundage disappeared."²

Mercury-Sparing

Typical of the Rolicton diuresis pattern is the ability of the drug to reduce and, in a large percentage of patients, to eliminate the need for mercurials parenterally.

"... the drug represents a most useful addition to our armamentarium in the treatment of edema, not only because it can be given orally ... but more so because it permits [us] to replace or to spare the ... mercurials."³

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

1. Asher, G.: Personal communication, June 23, 1956.
2. Settel, E.: A Clinical Evaluation of a New Oral Diuretic, Rolicton, *Postgrad. Med.*, Feb. 1957, in press.
3. Goldner, M. G.: Personal communication, June 29, 1956.

SEARLE

FROM OUR EXCHANGES

In an "Introduction to Reticulosis" (*Practioner*, 177:1058, pp. 123-132) attention is called by Harrison to the difficulty of making a diagnosis in many of the situations covered by the term reticulosis. The leukemias and polycythemia can be diagnosed by blood examinations. A few of the inflammatory reactions of reticular tissue may be diagnosed by bacterial or other indirect means. In a large residue of cases a final diagnosis depends on the histological examination of an excised lymph node.

The last group represents one of the most difficult tasks that the morbid histologist has to face. In the majority of cases an histological diagnosis is possible only if the material available for examination is technically good. Dr. Harrison mentions three sources of error. (1) The lymph nodes excised may not be affected by the disease. (2) The tissue may be traumatized in removal. (3) The tissue must be promptly fixed because without this the structure is rapidly lost. If these three criteria are fulfilled the diagnosis may still be difficult.

The author does not mention in his article the examination of bone-marrow smears. Many of the obscure forms of these diseases, including myeloma, can be diagnosed in a fairly early stage by means of an examination of a properly obtained bone-marrow smear. However, here again a negative or doubtful finding is not of much aid in making a positive diagnosis. Reticulosis is after all a broad and popular term. The reticular system responds in some degree to all inflammatory stimuli. Perhaps it is wise to compromise and restrict the term "reticulosis" to those diseases in which the main masses of reticular tissue are solely or mainly involved, and to omit those diseases in which the reticular tissue is only incidentally involved.

Finally, it has to be confessed that reticulosis is a term whose meaning has become uncertain. It is a group classification and to say that a patient is suffering from "reticulosis" is analogous to speaking of having an infection.

On the word of Meyers we can conclude that in some parts of the world tuberculosis is so well controlled that there is hope of its eradication (30,000

per 100,000, *Dis. Chest*, XXX:1, pp. 1-17). There is an opportunity here for the medical profession, which possesses the information and the armamentarium, to accomplish this goal.

The tuberculin test allows a chance to identify all persons harboring the tubercle bacilli. They have multiple lesions, some large but most are microscopic. X-ray film inspection reveals gross lesions but misses all others. Periodic x-ray film inspection is necessary to harvest this crop of minute lesions. Tuberculin reactors means that there is a case of tuberculosis; and the case must be so managed as to keep the tubercle bacilli corralled.

* * * *

"Medicine in a Changing World" by Allman is a needed discussion of the ethics of our profession. However, we are allowed to guess that the author's voice is a lone one in the wilderness (*N. Car. Med. Jour.*, 17:7, pp. 291-295). He is convinced "that what we need most today is a new revolution, a good revolution." He feels that Americans need to return to our starting point, to our early vigors of idealism and dedication. "There is work to be done of such magnitude that each must do his full conscientious best if we are to have a decent chance to win and survive." The times call for good doctors everywhere, and for good citizens. He is convinced that our problems are great and that therefore our strength must be great. He hopes that we will be remembered by those who follow after us as having had sufficient vision to recognize the twofold tyranny of our times—the tyranny of soviet despotism that threatens us from without, and the tyranny of selfish materialism that gnaws from within. We must possess the wisdom to perceive the evil and the courage and high valor to effectively resist it. The author expresses the idealism of John Locke (another physician). We can regret that there is lacking the eloquence of expression of John Locke which about two centuries ago made the revolution a living fact.

* * * *

"The Loss of Hearing, the Patient and His Problem," according to Wehr and Becker is one about which only one generalization can be made and that is that one cannot generalize about people and their



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"SAFETY, SKILL, COURTESY, COMFORT"

personalities, and that each person has a personality that is unique (*Ohio State Med. Jour.*, 52:7, pp. 709-715). The first step in adjusting to the problem of "hard of hearing" is to face the hearing loss and to accept it, rather than to try to pretend that it does not exist. The second step in treating these people is to encourage them to resume as full a life as possible. The person with a progressive loss of hearing tends to withdraw from favorite activities. Outside interests should be maintained and developed in order to meet the problem of reference. This feeling of reference is common to us all when we interpret outside events as referring to ourselves. Such feelings of reference can be held to a minimum if the "hard of hearing" is basically secure and feels that he is accepted by others around him. The third step in helping these people is that of encouraging them to investigate all possible measures to increase their communication ability, including lip reading and a hearing aid.

The idea that patients should not buy hearing aids until they are completely unable to get along in conversation should be discredited. The advantages of easy orientation to amplification while the loss is still moderate should be stressed. The misconception that a person with a nerve type of hearing loss is unable to use a hearing aid should be exploded, and replaced with encouragement to be satisfied with an increase in hearing performance, even though it may not approach perfect hearing. With the facilities now available it is reasonable to forecast a broadening and a more intelligent understanding and acceptance of hearing loss.

* * * *

Maurer states the following criteria in his discussion of "The Mechanics of Diagnosis in Allergic Disease" (*G. P.*, XIV:1, pp. 74-77). (1) A history of antecedent allergy. (2) A history of other definite allergies in the patient, either past or present. (3) A long standing history of recurrent attacks, not adequately explained on any other medical basis. (4) The presence of blood eosinophilia not attributal to intestinal parasites. (5) Pronounced positive skin tests properly confirmed. (6) The existence of definite symptoms frequently present in many of the accepted diseases of allergy.

* * * *

Torus palatinus according to James and Walters is a benign anomaly, usually first discovered during adult life (*G. P.*, XIV:1, pp. 78-80). It is a bony elevation at the middle of the palate and it takes

various shapes and sometimes is troublesome because of ulceration of the overlying mucus membrane or because it interferes with the fit of the dental plate. When first discovered it may awaken fears of a malignant neoplasm. Occasionally the physician shares that fear because he has forgotten about the nature of this harmless anomaly.

* * * *

Stevens reports on a controlled series of 35 cases of primary atypical pneumonia treated with Chlorotetracycline (*N. W. Med.*, 55:7, pp. 772-776). There appeared to be no, or little, effect on the average case, but it was dramatically effective in two cases. The author suggests that the conflicting reports on the value of Chlorotetracycline in atypical pneumonia may be explained by a variety of etiologic agents. It is suggested that a practical approach to treatment with tetracycline is to reserve it for those patients not recovering after a few days in bed.

* * * *

Bleeding in portal hypertension is an accident that is occasionally encountered in general practice. Welch *et al* review the life history of patients with cirrhosis of the liver who bled massively from the upper gastrointestinal tract (*New Eng. Jour. Med.*, 254:11, pp. 493-501).

In a series of 50 consecutive cases with cirrhosis of the liver and portal hypertension who bled, 33, or 66 per cent, died in the hospital, and 80 per cent died within one year of their hemorrhage. About one third of the patients who died after hemorrhage died in coma. Coma is due probably to an intoxication (absorption of digested blood) and is not an hepatic coma. The author suggests that ammonia intoxication best describes this metabolic derangement.

A program of treatment for patients bleeding with cirrhosis of the liver must take into consideration that coma may be preventable. The author advises the early use of the Sengstaken-Blakemore esophageal balloon tampon in addition to the usual blood-loss replacement and treatment of shock. Evacuation of blood from the entire gastrointestinal tract is an important step in the treatment of patients with esophageal varices and bleeding. (Milk of magnesia fed hourly through the tube combined with enemas or colonic irrigations.) Welch suggests that there is wisdom in the arguments that portocaval shunts should be performed in patients with cirrhosis of liver and esophageal varices before they bleed.

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President, Mrs. E. Roland Hill

Attend Clinical Session

Dr. and Mrs. Stanley B. Weld, Hartford, attended the Clinical Session of the AMA in Seattle, Washington, November 27-30. Mrs. Weld reports that the Woman's Auxiliary to the Washington State Medical Society with Mrs. J. Lester Henderson, chairman, had most interesting programs and entertainment planned for the wives who accompanied their husbands to the Session.

Excerpts From Board of Directors Meeting

December 3, 1956

It was voted by the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society that it cannot conclusively support the resolution concerning delegates to the National Convention, as presented by the Woman's Auxiliary of the State of Pennsylvania, as there is a definite need for further study of this question. Therefore, the Board suggests that a Committee of the National Auxiliary be appointed to study the important problem.

Mrs. Willard Buckley, hospitality cochairman, announced that the Annual Meeting will be held May 1 at the Hartford Golf Club, West Hartford.

Mrs. John A. Bucciarelli of Fairfield County has been appointed chairman of legislation to fill the unexpired term of Mrs. G. Gardner Russell.

Mrs. Richard Karpe, chairman of Mental, announced that a statewide educational meeting on some phase of mental health is being planned for late March.

Mrs. Royal A. Myers, *Today's Health* chairman, announced a total of 754 ³/₄ points which have been received by her for Connecticut to date.

Mrs. Saul Karpel, corresponding secretary, has sent letters of congratulations to Mrs. Robert J.

Cook, New Haven, a past State president, and Mrs. Paul Vestal, Woodbridge, formerly editor of the *Bulletin*, on their elections as representatives to the State Legislature.

Mrs. Robert W. Nespor, Fairfield, reported \$500 realized on their dance for scholarships and AMEF.

In the absence of Mrs. John D. O'Connell, Mrs. Paul W. Tisher reported that thirteen scholarships have been granted by the Hartford County Auxiliary to young people in medical or nursing fields.

Mrs. Edward T. Wakeman, president of New Haven County, reported that thirty one volunteers had reported to a call for CD volunteers.

Mrs. Louis Soreff, Middlesex County, reported that a number of members had volunteered to wrap Christmas gifts at the Connecticut State Hospital for patients, also that Mrs. Walter Nelson, Cromwell, was appointed to the Middlesex County Committee, Connecticut Child Welfare Association.

Sally M. Tracy

Malpractice Prevention in San Francisco

The San Francisco Medical Society has adopted a four point program to enhance its malpractice prevention program:

1. Each hospital has been asked to appoint its own Review and Advisory Committee to act in liaison with a similar committee of the Society.

2. A prominent layman will serve in an advisory capacity on the Society's committee.

3. Formation of a panel of medical experts "who will be available when needed by the attorneys of plaintiffs."

4. One hundred per cent cooperation with the California Medical Association in its over-all education program now under way.

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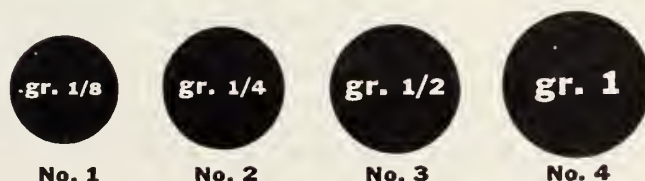
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AROUND THE STATE

Connecticut Regional Blood Program

At the Clinical Meeting of the American Medical Association in Seattle in late November, there was presented a paper by Dr. Harriet E. Judy, M.D. and Noreen Brandt Price, Ph.D., on the normal red blood count and hemoglobin in healthy women. Their study was extensive and thorough.

The authors believe that any attempt to raise a women's hemoglobin higher than 12.5 Gm. or the red blood count higher than 4,370,000 is probably a waste of time and money.

This paper is of interest to the blood program because the standard of hemoglobin set for the acceptance of female donors is 12.5 Gm. We know from experience that the percentage of rejections for low hemoglobin in women is much higher than in men. The standards quoted above are perhaps also of interest to clinicians in their decision whether or not to use blood to elevate the blood count and hemoglobin in surgery on women.

Statement of Policy

It has been brought to the attention of the Regional Blood Committee that residents of this State are having difficulties with hospitals in Boston which are insistent upon prior replacement of blood or the prior deposit of money to cover the cost of professional donors.

As you are aware this program was designed to cover the needs of our Connecticut hospitals and that there are, in fact, contracts with the hospitals. On the other hand it is felt that many of our donors who have loyally supported the Connecticut program with their blood should not be penalized if by chance or design hospitalization is required outside the confines of this State. This program does not provide coverage for any Connecticut resident but in general will try to help only those of our residents who have personally supported this program by blood.

There are certain requirements which must be met before a Connecticut resident hospitalized out of State can receive the benefits of this program. Your local Red Cross Chapter can guide you concerning this. If such requirements are met, this Center is

prepared to issue in advance a statement to the individual which can be presented to the out-of-state hospital assuring that hospital that the blood needs of the patient will be met. It is believed that when definitive arrangements are being made for hospitalization outside the State, physicians can, by this procedure, relieve their patients of embarrassment in cases in which large sums of money or large amounts of blood are peremptorily demanded on admission.

DONORS	JULY 1, 1956 THROUGH	
	DECEMBER 1956	DECEMBER 31, 1956
Donors accepted	6,812	43,360
Donors rejected	700	4,650
Donors registered	7,512	48,010
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from center	6,510	37,058
Blood collected by hospitals.....	383	3,921
To fractionation stock pile.....	126	261
To out of state hospitals.....	106	572
	7,125	41,812
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	59	559
Processed into packed cells.....	9	34
Processed into liquid plasma.....	1,066	5,431
	1,134	6,024
Discarded — unfit and broken.....	75	323
Grand Total — distribution of blood....	8,334	48,159
Blood returned to center for processing into plasma and fractions.....	1,038	4,595
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	59	216
Fresh frozen plasma (125 cc.).....	158	1,158
Serum albumin (100 cc.).....	139	1,165
Packed red cells (bottles).....	9	34
Fibrinogen (bottles)	0	8

Connecticut Committee on Foods, Drugs, Cosmetics and Devices Meeting of December 6, 1956

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experi-

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ment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner, Jr.; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; University of Connecticut, Dr. Stanley E. Wedberg.

The following were also present: Dr. Felix Blanc, representing the Pharmacy Commission; Dr. Benjamin Katzin, chairman of the Joint Committee of the State Medical Society and the Pharmaceutical Association; Mr. Herbert Plank, representing the Food and Drug Commission.

THE FUTURE STATUS OF THE COMMITTEE

At the October 4 meeting it had been agreed that at the December meeting a vote would be taken upon certain proposals of Dr. Hewitt and Prof. Fenney with regard to the name and composition of the Committee and its relationship to the Joint Committee of the State Medical Society and the Pharmaceutical Association. This subject was therefore brought up at the present meeting and discussed at some length. The Committee finally voted unanimously that, subject to ratification by the sponsoring agencies, the following changes in the status of the Committee be made:

(1) The Committee be declared to be independent of the Joint Conference Committee and responsible directly and solely to the sponsoring societies and institutions.

(2) Its name be changed to "The Connecticut Advisory Committee on Foods and Drugs."

(3) The representatives of the Food and Drug Commission, the Pharmacy Commission and the State Department of Health be granted membership on the Committee without vote.

(4) The number of regular meetings per year be reduced to five, with a sixth (December) meeting to be held only upon request of two members.

The secretary-treasurer was directed to notify the sponsors of this action of the Committee and ask for their ratification; he was also directed to inform the Joint Conference Committee of the vote upon autonomy and changes of name.

Dr. Katzin told the members that the question of autonomy of our Committee had been discussed at the October meeting of the Joint Conference Committee, and that the members of his committee had agreed then that the stature of our Committee was now such, and our objectives were so different, that they should relinquish any claims to control over us that they may have had due to the fact that historically we started as a subcommittee of theirs.

PROFILE SPECIAL FORMULA BREAD

At the October 4 meeting Dr. Fisher had shown the members a full-page advertisement of this bread from the *New Haven Register* of September 13, 1956 which was headed: "Now! A Bread to Help You Control Weight!" Because of the extravagant nature of the claims in this advertisement, he had recommended that it be referred to Dr. George Cowgill, professor of nutrition of the Yale University School of Medicine, for his opinion. Prof. Fenney had done this, and received a written reply from Dr. Cowgill dated November 29, which he read to the members.

After listening to Dr. Cowgill's report it was voted, upon motion of DeVita seconded by Kirschner, that it be the opinion of the Committee that the advertising of "Profile Special Formula Bread" was misleading if not false.

DERMA TEEN COMPANY PROFESSIONAL WATER PURIFIER

The Connecticut Pharmaceutical Association had asked our Committee for an opinion on the validity of the "Derma-Teen" advertising claim that tap water passed through their deionizer unit was equivalent to USP Purified Water, which may be used wherever "distilled water" is called for in a prescription.

Prof. Fenney remarked that the USP monograph for "Purified Water" listed "Distilled Water" as a synonym, and defined this product as "water obtained by distillation or deionization." The USP cautioned, however, that Purified Water should not be used for parenteral administration or in preparations to be used parenterally; for such preparations Water for Injection USP XV, which was sterile water purified by distillation, had to be used.

It was the consensus of the Committee that tap water passed through the deionizer unit described in the pamphlet of the Derma Teen Co., Sanford, N. C., could be used where "distilled water" was called for in prescriptions not for parenteral use, provided the product was up to its advertised claims and was equipped with some means of indicating when the cartridge was exhausted.

CONFERENCE ON POISON CONTROL CENTERS IN CONNECTICUT

Dr. Fisher reported that at the invitation of State Health Commissioner Osborn Prof. Fenney and he had represented the Committee at a conference on the proposed establishment of poison control centers in Connecticut which was held in Dr. Osborn's

ARTHRITIS AND RELATED DISORDERS

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585A Orthopedic Aspects of the Treatment of Rheumatic Disorders. Tuesdays, 9:00 A. M. to 5:00 P. M., March 19 through April 2, 1957. Designed to follow immediately after course 544A above. Under the direction of Dr. Robert L. Preston Tuition \$50.00

All applications and inquiries concerning admission to these courses should be addressed to the office of the Dean, New York University Post Graduate Medical School, 550 First Avenue, New York 16, N. Y.



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office in Hartford on October 26. At this meeting, after Dr. Press had described the functioning of poison control centers in other States, all agreed that it was desirable for one or more such centers to be established in hospitals in Connecticut; the only doubt expressed was as to whether sufficient funds could be obtained for properly manning the center (or centers). The conference resulted in Dr. Osborn's appointing the following committee to study this subject further and come up with specific recommendations; Dr. Fisher (chairman), Drs. Joseph and Price, Mr. Keehn, Mr. Plank and Mr. Stewart Knox.

TES-TAPE

At the meeting of May 26, 1955 Dr. Greenhouse had demonstrated "Tes-Tape," a paper tape recently put out by Eli Lilly & Co. for making sugar tests on urine. At the present meeting Dr. Fisher called the members' attention to the fact that the November 1956 issue of "Analytical Chemistry" [28, 1748 (1956)] carried an article by J. P. Comer describing in detail the composition of this tape and the tests made to establish its specificity to dextrose.

Admission Policy Veterans Home and Hospital Rocky Hill, Connecticut

1. A waiting list, for the admission of patients not acutely ill, shall be established.

The clinic physician, or, in his absence, the admitting physician, may defer admission to any but the acutely ill patient.

The executive-officer, hospital, shall establish a waiting list for the admission of patients who are not acutely ill, to all departments of the hospital; the duration of time prior to admission to be coordinated with the chief of service, to which the patient may be admitted.

2. Arrangements in advance for admission on a scheduled basis shall be required.

A policy is established to defer admissions to the hospital until the facility is adequately staffed to care for them.

"Walk In" admissions shall be discouraged. The Commission requires an application in advance.

The exception to the above policy is that emergency cases will be admitted at all times.

3. Admission of repeat alcoholics shall be denied.

A veteran applying to this hospital for admission who is in a state of incipient D.T.'s needs active treatment and close supervision and since neither is available at this facility for this type of patient, he shall, if he requests care, be transferred to a mental institution.

4. Veterans accepted for admission shall be processed on Mondays through Friday, from 8:30 A. M. to 4:30 P. M. only.

Veterans desiring admission who are deferred pending available beds should return home and await admission. If this is not possible, they shall be admitted to the barracks, if a bed is available, after a preliminary short form physical examination conducted in the Clinic on an outpatient basis.

5. Applicants for readmission who do not require hospital care or who are not acutely ill shall be admitted directly to the barracks, if a bed is available, after a short form physical has been completed by the Clinic physician.

This is not to be construed as to permit applicants for readmission to appear without prior notice, or after working hours, or on a Saturday or Sunday.

Cancer Survival Rates in Connecticut

"Cancer in Connecticut—1935-1951" written by Griswold, Wilder, Cutler and Pollack of the State Department of Health, gives figures to show there is a pronounced improvement in cancer survival rates for various sites over the three time periods, 1935-1940, 1941-1946, and 1947-1951. When the follow-up through the end of 1953 became available, revised figures of the estimated rates for the 1947-1951 cases were made. Full five year survival rates for the 1947-1948 period are available. It has been indicated in the monograph that, since survival from cancer becomes substantially stable after the first year, preliminary estimates of survival can be made without the full five year follow-up and that these rates can be accepted with a reasonable degree of assurance.

Dentists Issue News Letter

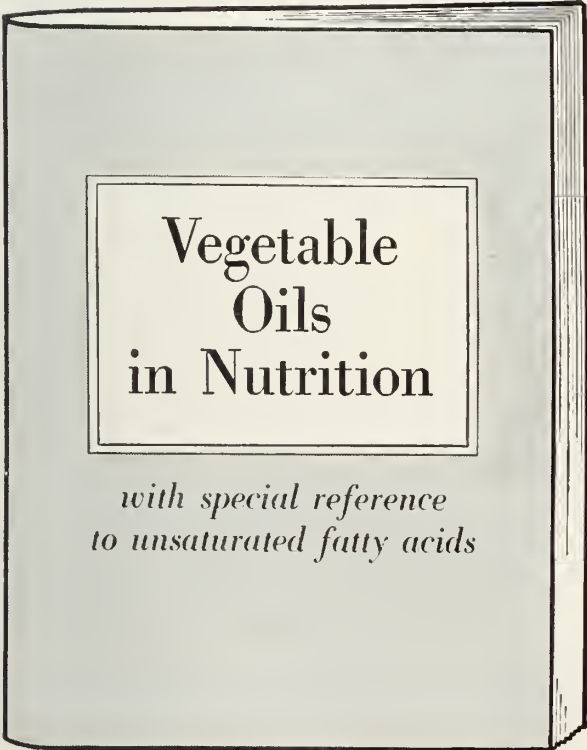
The Connecticut State Dental Association has begun the issuance of a News Letter as a complement to, not a substitute for, its Journal. Typical of the contents is the following:

FLUORIDATION

30,490,000 people in 1,432 communities are now drinking fluoridated water. Six million people in

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*Timely, Comprehensive, Useful... with special reference
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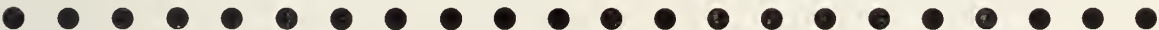
COMPREHENSIVE . . . a review of authoritative experimental and clinical research pertaining to the special metabolic roles of polyunsaturated fats

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The role of dietary lipids in health and disease is universally assuming new importance. Evidence is accumulating that quality of the dietary fat may be more important than quantity.

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171 areas have been brought under program in '56. Connecticut continues to lag behind. The Council of Dental Health of the CSDA has appointed a subcommittee of fluoridation whose main function is to formulate a program of education, for the dental profession as well as the public. Information on the progress of fluoridation programs may be obtained from W. Harry Siemon, New Canaan; Joseph J. Castanza, New London; Harold B. Knapp, Danbury; Harold Singer, Torrington; and Gordon Ten Broeck, New Haven.

Hospital Accreditation in Connecticut

When the Joint Commission on Accreditation of Hospitals was formed in 1953, a total of 31 general hospitals in Connecticut were meeting the requirements of the American College of Surgeons. At present over 90 per cent of the general hospitals in this State are meeting the rigid standards of the Joint Commission.

Fairfield County

William M. Stahl, Sr., a leading Danbury surgeon for the past 37 years, died in the Danbury Hospital on December 11, 1956 at the age of 65. Dr. Stahl was a past president of the Fairfield County Medical Association and a former chief of the surgical staff at Danbury Hospital.

R. Edward Vioni has assumed the presidency of the medical staff at St. Vincent's Hospital, Bridgeport. He succeeds Joseph C. Quatrano in that office. Officers also elected were Richard J. Sekerak, vice president and Francis X. Foley, secretary-treasurer. A staff banquet, at which installation took place, was held last month.

Atty. Mansfield Sprague, New Canaan, the son of Dr. and Mrs. Charles H. Sprague of Bridgeport, has received a recess appointment by President Eisenhower as assistant secretary of the Department of Defense.

Two Stamford physicians, Bernard O. Nemoitin and M. Joseph Mancinelli, were elected recently president and secretary, respectively, of the Exchange Club in that city.

Hartford County

HARTFORD COUNTY SOCIAL SECURITY POLL

Returns, on a recent Social Security Poll, after a few ineligibles had been eliminated, showed a 66 plus percentage. Those favoring social security were

56 plus per cent of the entire membership (including some members who were already covered) while 8 plus per cent voted against (none in this group mentioned already existing coverage). The ratio was six and one half for against every one not in favor.

Another interesting aspect of the poll was the fact that 40 or more return cards were hand delivered and 26 came in without postage. There were no anonymous answers—each card was signed. In fact, several were tandem, with two or more signatures. One doctor preferred a regulation postal card, but worded his question exactly as it was on the original. Several members over 65 voted yes without any qualifications, a few voted yes but felt that they had to report that they were ineligible to receive the law's benefits. Seventeen members who were already covered by the law, abstained from making a selection. One physician took advantage of his vote by also calling the Hartford County Medical Association executive officer's attention to the fact that he had changed his address.

Only one physician commented that he thought the questionnaire inadequate, though he voted yes. Many individuals expressed statements ranging from "How can anyone be for CMS and against this?" and "It's not a case of 'would like' or 'not like.' That is not relevant. If most citizens have to submit to the ignominy—why should a small, unsufferably (sic) 'elite' group skin out of it?" to "Coverage would be a travesty upon an individual's basic freedom to provide his own security . . ." There were other expressions of opinion: "I am covered and like it." "I would approve of voluntary coverage." and "But definitely!"

Final figures of 507 were for security coverage, 76 against and seventeen not voting.

DR. TOVELL RECEIVES UNUSUAL HONOR

At the 62nd annual meeting of the Horace Wells Club held in Hartford on December 8, 1956 Ralph W. Tovell, chief of the Department of Anesthesiology at the Hartford Hospital, was presented with the first Horace Wells Anesthesia Award. The presentation was made by Robert H. W. Strang, M.D., D.D.S. Dr. Tovell received the award with a gracious speech of acceptance.

The Woman's Auxiliary have awarded, through their Scholarship Fund, a total of \$3,650 to thirteen medical students for the school year of 1955-56.

New officers of Hartford hospital staffs are: Nicholas A. Giorgio, president of the medical-sur-

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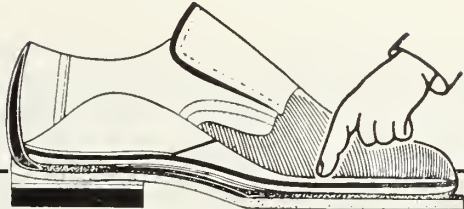
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gical staff at St. Francis Hospital. Manuel S. Hirschberg heads the medical staff at Mt. Sinai and Ralph T. Ogden is president of the Hartford Hospital medical and surgical staff.

Named president-elect of the St. Francis staff is Lewis P. James. Other officers are: James Missett, secretary; Edward White, assistant secretary; Timothy L. Curran, treasurer; Thomas M. Feeney, chairman of the executive committee and John O'Connell and Thomas Murphy to the executive committee.

Elected vice president of Mt. Sinai staff is Louis D. Harris, and treasurer, David S. Slossberg.

Vice president of the Hartford Hospital staff is G. Gardiner Russell and secretary, R. Starr Lampson. New members of the executive committee are John E. Cartland, Sidney K. McPherson, John G. Martin and Frank O. Wood.

A new member of the American College of Gastroenterology is Marcel Thau of Hartford.

Medical staff members of Mt. Sinai Hospital recently paid tribute to Isadore S. Geetter for his ten years of service to Mt. Sinai Hospital.

Honored recently by the New Britain Exchange Club was Jacob Mellion, director of health service in New Britain's schools. He was presented with the Exchange Club's Certificate of Award which is given each year by the Club to the person deemed most outstanding over the years to athletes and athletics at New Britain High School.

Attending the annual meeting of the American College of Surgeons recently were: Maurice Pike, Rembrandt H. Dunsmore, Benjamin B. Whitcomb, Chester A. Wiese, Jr. and Dwight R. Wood of Hartford and Harold M. Clarke of New Britain.

New president of the Connecticut Trudeau Society is William J. Lahey of St. Francis Hospital.

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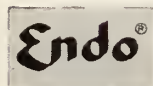
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A compilation released this month by the State Health Department's division of local health administration reveals that tax funds channeled into public health services in Connecticut ranged from a low of two cents per capita to a high of \$3.85 in 1955. This report was released by Henry P. Talbot, acting chief of the division.

On a statewide basis, expenditures per person averaged \$1.51. Hartford, with a listed population of 187,400, topped the State's big cities with an expenditure of \$2.58 per capita.

Dr. Talbot's listing of expenditures in other communities in Hartford County were: Bloomfield, \$1.18; Farmington, \$1.29; Glastonbury, \$2.44; Newington, \$1.17; East Windsor, \$1.04; Enfield, \$0.58; Rocky Hill, \$1.85; South Windsor, \$1.15; Avon, \$0.75; Canton, \$0.86; Plainville, \$1.27; Simsbury, \$1.62; Wethersfield, \$0.70; Windsor, \$0.83; Windsor Locks, \$1.05; Manchester, \$1.22; East Hartford, \$1.44; New Britain, \$1.59; and West Hartford, \$1.43.

Dr. Talbot noted the 1955 State average of \$1.51 per capita from tax funds is slightly higher than the \$1.43 the year previous, an increase which he attributes largely to increased fees, salaries and cost of materials.

The data gathered in the study is prepared to serve the communities as a guide to the proper health conditions that should prevail. As a rule, he stated, "the per capita cost is an index to this protection."

The Hartford Medical Society held its first annual meeting in its new home on Scarborough Street on January 7. Thacher W. Worthen was inducted into office as president, succeeding Samuel Donner. The other officers elected were Lewis P. James, president-elect; R. Leonard Kemler, secretary; James E. Messett, assistant secretary; Arthur C. Unsworth, treasurer; Maurice F. O'Connell, assistant treasurer; Ernest Caulfield, librarian; William J. Lahey and John C. Leonard, associate librarians; Louis P. Hastings, trustee for three years; and Louis H. Gold, member house committee for three years.

Maurice W. Maloney, who retired in 1955 as the oldest practising physician in Connecticut, died at the New Britain General Hospital, January 10, at the age of 88.

John Law Bridge, one of the oldest members of the Hartford County Medical Association, died at his home in Hazardville on January 9. Dr. Bridge, who reached the venerable age of 97 years, had been a teacher in his early years at both Suffield Academy and Waterbury High School before entering Harvard Medical School.

Union and New Haven Trust Company Pays Tribute to David Lyman

In the December, 1956 issue of its *Journal*, the Union and New Haven Trust Company pays a delightful tribute to one of its own advisory committee members, the late David R. Lyman. The bank recounts the history of Gaylord Farm with many personal touches added, and hints of its future usefulness under the present staff. Pictures of some of the staff are included.

One page is given over to a short biography of Dr. Lyman beneath one of his recent pictures showing that enjoying smile which we all loved to see. The closing paragraph is expressive: "Today there is a new Gaylord which is a living memorial to Dr. Lyman. We can assure you that the torch which Dr. Lyman kept lighted for half a century has been passed on to hands and hearts fully as dedicated as his own."

New Haven County

Edward H. Hon and O. W. Hess of New Haven won second award at the recent meeting of the American College of Obstetricians and Gynecologists for their scientific exhibit on "A Study of Fetal Cardiac Energy."

Herbert Thoms of Hamden is the author of "A Consideration of Childbirth Programs" published in the *New England Journal of Medicine*, November 1, 1956; also of "The American Obstetric Heritage" which appeared in *Obstetrics and Gynecology*, November, 1956.

Nicholas M. Greene of New Haven is the author of "Anesthetic Management of Patients With Respiratory Disease" published in the *Journal of the American Medical Association*, December 1, 1956.

The staff physicians of St. Mary's Hospital, Waterbury have just contributed almost \$100,000 toward the building fund whose total goal is \$750,000. The purpose of the drive will add new facilities to St. Mary's Hospital.

Orpheus J. Bizzozero has been elected chief of staff of Waterbury Hospital. John Freiheit has been elected president of the hospital staff.

William Finkelstein has been elected chief of staff of St. Mary's Hospital. Vincent Shea has been elected president of the staff.

At a recent meeting of the Waterbury Medical Society, Russel Sumpf, editorial writer of the Waterbury newspaper, was the guest speaker. The relation of newspaper to the medical profession was discussed by Mr. Sumpf. The meeting was of mutual interest to both the press and the medical profession.

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SPECIAL NOTICES

EDUCATIONAL PROGRAM FOR THE MIDDLE-SEX MEMORIAL HOSPITAL AT MIDDLETOWN FOR FEBRUARY, 1957

- Friday, February 1, noon
Grand rounds
- Monday, February 4, noon
Clinical-pathological conference
- Wednesday, February 6, 10 A. M.
Tumor clinic
- Friday, February 8, noon
Grand rounds
- Monday, February 11, noon
Management of peripheral vascular disease
Dr. William E. Bloomer
- Friday, February 15, noon
Grand rounds
- Monday, February 18, noon
Diagnosis and therapy of menstrual disorders
Dr. Walter Herrmann
- Friday, February 22, holiday
- Monday, February 25, noon
Atypical variants of viral hepatitis causing cirrhosis
Dr. Gerald Klatskin
- Wednesday, February 27, noon
Herniated nucleus pulposus
Dr. Gilbert H. Glaser

150th ANNIVERSARY CONVENTION Medical Society of the State of New York New York City, February 18-21, 1957

An important milestone in 150 years of Empire State history will be reached when the Medical Society of the State of New York celebrates its Sesquicentennial in convention at the Hotel Statler in New York City, February 18-21, 1957.

With history as the keynote, the Society has arranged for the Convention numerous and diversified events which are expected to be of widespread interest to both the membership and the general public.

Among the Sesquicentennial high points, and of particular interest to the profession, will be an excellent four-day scientific program and a magnificent anniversary banquet. The scientific program will consist of general sessions, symposiums and panel discussions, closed-circuit color television, scientific motion pictures, and scientific and technical exhibits. In the scientific exhibits section, especial care in plan-

ning is being taken to assure an array of subjects with wide appeal.

Scheduled to deliver scientific papers are outstanding physicians from various parts of the United States and from abroad, in addition to doctors from New York State.

Throughout the Sesquicentennial Convention, the Society will sponsor and conduct expressly for the general public a non-scientific Exposition of the History of Medicine in the Empire State. The Exposition will depict "Progress in the Art of Medicine from Colonial Times to the Atomic Age," and will consist of individual displays showing the histories of various types of medical, dental and ancillary institutions throughout the State. The event will be held at the Hotel Statler each day and on three evenings, with no cost for admission.

10th INTERNATIONAL CONGRESS INTERNATIONAL COLLEGE OF SURGEONS Mexico City, February 24-28, 1957

The International College of Surgeons extends a cordial invitation to all physicians, medical personnel and their friends to attend its Tenth International Congress in Mexico City, February 24-28.

The meeting is being held at the invitation of His Excellency, Don Adolfo Ruiz Cortines, President of Mexico. It will combine an excellent scientific program by outstanding surgeons of the world with an opportunity to enjoy the show places of Mexico.

Four days will be devoted to the scientific program, to be presented at the University of Mexico. This will cover all phases of surgery. Blocks of rooms have been set aside in Mexico City's finest hotels for those attending. Social functions have been scheduled. For those who wish to see something of the country, two postcongress tours have been arranged.

In view of the large attendance which is expected, and the shortness of time, reservations should be made at once. To simplify the making of arrangements, the International Travel Service, Inc., Palmer House, Chicago 3, Illinois, has been chosen to handle registrations for the Congress, hotel reservations and travel. Inquiries for further information should be directed to the International Travel Service, Inc.

AMERICAN COLLEGE OF SURGEONS, WASHINGTON, D. C., MARCH 18-21, 1957

A Sectional Meeting of the American College of Surgeons will be held in Washington, D. C. March 18-21, 1957, at the Sheraton-Park Hotel. Attendance is not limited to Fellows of the American College of Surgeons, but rather open to all interested in surgery. Non-Fellows are charged a \$5 registration fee. Save the date now—detailed program later.

National Health Forum
Cincinnati, Ohio
March 20-22, 1957

AMERICAN TRUDEAU SOCIETY

Announces a postgraduate course: "The Measurement of Pulmonary Function in Health and Disease." Sponsored by the Medical Schools of Harvard University, Tufts University, and Boston University, the Harvard School of Public Health, the Massachusetts Tuberculosis and Health League, and the Massachusetts Trudeau Society, Boston, March 25-29, 1957, 9:00 A. M. to 5:00 P. M.

A course aimed at physicians interested in diseases of the chest who wish to acquaint themselves with the methods used in the evaluation of pulmonary function. Methods of analysis of pulmonary function and related cardiac function will be described and demonstrated. Tuition \$75.

Applications and more detailed information may be obtained from Edward J. Welch, M.D., chairman, Regional Committee on Postgraduate Courses. Address: 1101 Beacon Street, Brookline 46, Massachusetts.

9th Annual Scientific Assembly
American Academy of General Practice
St. Louis, Missouri
March 25-28, 1957

37th Annual Meeting
American Association for Thoracic Surgery
Chicago, Illinois
April 4-7, 1957

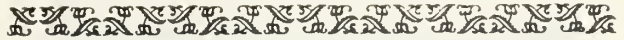
6th International Congress of Otolaryngology
Washington, D. C.
April 5-10, 1957

10th World Health Assembly
Geneva, Switzerland
April 7, 1957

64th Congress of the French Society of Ophthalmology
Paris, France
April 12-16, 1957

4th Latin-American Congress of Oto-Rhino-Laryngology
and Broncho-Esophoscopy
Lima, Peru
April 15-30, 1957

Congress of the International Association for the
Study of the Bronchi
Lisbon, Portugal
April 25-26, 1957



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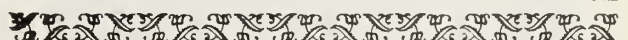
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Annual Health Congress
Folkstone, Kent, England
April 30-May 3, 1957

COURSE ON SURGERY OF NASAL SEPTUM

A postgraduate course, "An Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," will be presented at the Yale-New Haven Medical Center by Yale University School of Medicine, department of surgery, section of otolaryngology, in cooperation with the American Rhinologic Society and Grace-New Haven Community Hospital, May 11-18, 1957. The course, under the guest direction of Dr. Maurice H. Cottle, Chicago, will consist of didactic lectures, case presentations, cadaver dissections, and observation of operations. Enrollment is limited. Applicants must be diplomates of the American Board of Otolaryngology (or its equivalents for doctors from other countries). Scholarship assistance is available to a limited number of foreign applicants. For information write the Assistant Dean of Postgraduate Medical Education, Yale University, School of Medicine, 333 Cedar St., New Haven 11, Conn.

Congress on Metabolic Disorders of Gynecological and
Obstetrical Origin
Coutrexeville, France
May 31-June 2, 1957

International Congress of Public Health Physicians
and Surgeons
Turin, Italy
June 1-9, 1957

5th International Congress of Therapeutics
Utrecht, Netherlands
June 5-7, 1957

9th International Congress of Rheumatic Diseases
Toronto, Canada
June 23-28, 1957

4th International Orthopedic Congress
Rome, Italy
June 23-28, 1957

12th International Congress of Industrial Medicine
Helsinki, Finland
July 1-6, 1957

6th Congress of the International Society of
Geographical Pathology
Paris, France
July 9-12, 1957

4th Congress of the International Congress of Gerontology
Merano, Italy
July 14-19, 1957

3rd International Congress of Clinical Pathology
Brussels, Belgium
July 15-20, 1957

3rd International Congress of Neuropathology
Brussels, Belgium
July 21-29, 1957

Meeting of International League Against Epilepsy
Brussels, Belgium
July 21, 1957

6th International Neurological Congress
Brussels, Belgium
July 21-28, 1957

International Congress of Electroencephalography
and Clinical Neurophysiology
Brussels, Belgium
July 21-29, 1957

1st International Congress of Neurosurgery
Brussels, Belgium
July 21-29, 1957

7th World Congress of International Society for the
Welfare of Cripples
London, England
July 22-26, 1957

Symposium on Cancer
Perugia, Italy
July 24-29, 1957

11th General Assembly
World Medical Association
Istanbul, Turkey
September 29-October 5, 1957

INTEREST SHOWN IN INTERNATIONAL MEDICAL FILM PROGRAM

The international medical film program, new feature of the American Medical Association's 1957 annual meeting, is creating considerable interest abroad, according to Ralph P. Creer, director of Motion Pictures and Medical Television, American Medical Association. Many applications are now coming in, indicating an extensive program of medical films made in other countries.

The aim of the film program is to bring before the doctors attending the meeting outstanding motion pictures produced abroad dealing with many aspects of medical science. This feature is in support of the People-to-People

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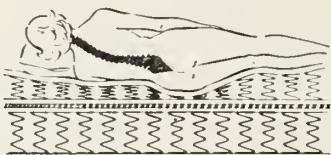
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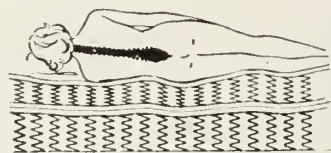
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Program which President Eisenhower launched this summer and in which the Medicine and Health Professions are co-operating under the chairmanship of Dr. Louis H. Bauer, Secretary-General of the World Medical Association.

Although the film program is in no way competitive, a Certificate of Participation will be awarded to each film of distinction selected for showing.

In connection with this film program, which is to be held at the Barbizon Plaza Hotel in New York City June 3-7, 1957, a discussion is planned on the problems of a freer international medical film exchange. All country representatives interested in dissemination of medical knowledge by the film medium are invited. Special social events will also provide an opportunity for the participants to meet informally and discuss problems of mutual interest.

The film program will be scheduled so as to permit participants to visit scientific exhibits and other programs, including color television, as guests of the American Medical Association.

Applications for the program and further information can be obtained from the American Medical Association, Motion Pictures and Medical Television, 535 North Dearborn Street, Chicago 10, Illinois.

NEW BOOKS IN REVIEW

EDUCATING SPASTIC CHILDREN. By F. Eleanor Schonell, M.D., PH.D. Formerly Research Fellow, University of Birmingham, Department of Pediatrics and Child Health. New York: Philosophical Library. 1956. 242 pp. \$6.

Reviewed by RUSSELL V. FULDER

Dr. Schonell's clearly written, logically organized monograph provides broad consideration of the special educational needs of spastic or—to use the preferred American term—cerebral palsied children. While the work will find its greatest use in the hands of teaching and technical personnel it will also make a worthwhile reference for physicians dealing with brain-injured children. The volume is of attractive format and of a size that handles well.

Following an introductory section the author describes and evaluates her experience with the cerebral palsy research project conducted by the University of Birmingham, in the English Midlands, beginning in 1947. Her especial interest was to determine the intelligence and reading abilities of the children involved. The Terman Merrill Intelligence Scale, which Dr. Schonell considers the most effective intelligence test for cerebral palsied children, indicated an I.Q. of better than 70 in 51 per cent of those tested. About 45 per cent of the children fell into the mentally retarded category. Closely tallied by Hohman's results in a North Carolina survey three years ago, these figures appear to represent fairly the distribution of intelligence in an unselected cerebral palsy population. Dr. Schonell's study of reading abilities brought to light a number of significant findings, the most surprising being that very few cerebral palsied children—only 7 per cent, in fact—with I.Q.'s over 70 are unable to read. This observation provides the exam-

ining physician with a valuable diagnostic aid in his initial appraisal of the cerebral palsied child. The second half of the book is a design of educational practice: selection of a curriculum, provision for varying degrees of mental and physical handicap, techniques for teaching reading and arithmetic. Properly stressed is the importance of an optimum psychological climate in training the cerebral palsied child, and the parents' role in attaining it.

In view of the generally excellent quality of her presentation, it is unfortunate that the author allows herself to repeat an idle imputation concerning her distinguished countryman, Dr. William J. Little. In Dr. Schonell's words: "nothing was done (for cerebral palsy) because doctors accepted the attitude of Little that cerebral palsy cases were probably of low-grade mentality and little or nothing could be done to improve their condition." This absurd attribution seems to be an American invention; at any rate it has appeared in the publications of American writers who ought to know better. The truth of the matter is quite opposite: Little's attitude was as optimistic as that of our most dedicated moderns. To quote from his definitive treatise (1862): "I have had many of these cases under observation from one to twenty years, and may mention as an encouragement to other practitioners that treatment based upon physiology and rational therapeutics effects an amelioration surprising to those who have not watched such cases. Many of the most helpless have been restored to considerable activity and enjoyment of life. Even cases which exhibit impaired intellect may be benefited in mind and body to an unexpected extent."

HUSBANDS AND PREGNANCY. *The Handbook of Expectant Fathers.* By William H. Gemé, Teacher-Counselor, The Clara Elizabeth Fund for Maternal Health, Flint, Michigan. New York: Association Press. 1956. 127 pp. \$2.

Reviewed by STANLEY B. WEID

Flint, Michigan, like New Haven, Connecticut, has distinguished itself for its leadership in the education of both husband and wife for the experiences of pregnancy, labor, and the postpartum period. Probably some of the credit for this forward step belongs with the author of this book, for within its covers may be found much valuable common sense as well as considerable information to which it is doubtful if the average expectant father would be exposed. The mere fact that the author enjoys the title of teacher-counselor for a maternal health fund lends authority to his writings and implies an active participation in the antepartum education of both husband and wife.

The book is very readable, even a bit racy in places, and should be afforded a warm reception by expectant fathers who often pick up their information from another husband who has graduated to fatherhood. The author really supplies the keystone to his effort when he says "pregnancy, in a very real way, is the testing ground of marriage and the training ground for parenthood."

Obstetricians who read this volume may be reminded of their shortcomings in supplying information to the husbands of their patients. At least they should recommend the book to every expectant father on their list.

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CHARTER AND BY-LAWS — CONNECTICUT STATE MEDICAL SOCIETY

February, 1957

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Board of Censors	IX	3	3	Duties	VI	2	4
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	IX	1	2	Meetings	VIII	2	4
	IX	1	3		VIII	3	1
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Apportionment	XIII	9	1	Associate	V	4	1
	XIII	9	2	Classes	V	1	1
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	Charter		5	Honorary	V	5	1
Discipline	XIII	7	1	Requirements	V	2	1
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	XI	2	1	Student	V	3	1
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Duties	VI	2	1	Rules of Order	XV	1	1
President-Elect				Speaker of House of Delegates			
Duties	VI	2	2	Duties	VI	2	7
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	XII	1	2				

THE CHARTER AND BY-LAWS

(Reprinted February 1957)

The Connecticut State Medical Society was incorporated and chartered by the Connecticut General Assembly in 1792. This is believed to be the earliest private charter granted by the State of Connecticut. The Society has no constitution, the articles of incorporation serve that purpose and cannot be amended without legislative action. The By-laws implement the Charter and it is under them that affairs of the Society are carried on. The By-laws can be amended at any meeting of the House of Delegates after proper notice and they are often revised to keep pace with the progress and changing responsibilities of the Society. The By-laws now published include all amendments to date. The first meeting of the Society was held in Middletown on October 9, 1792.

CHARTER

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suits of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismission and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all monies and other property belonging to the corporation in such manner as it may deem advisable to promote the objects and interests of the society and in general to make such by-laws and

regulations for the due government of the society, not repugnant to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of the Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society, (2) delegates to be elected annually as hereinafter provided, by the several county medical associations in this State which heretofore have been and are affiliated with the Connecticut State Medical Society and (3) the members of the Council of the Society.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held upon such day in each year as The House of Delegates shall, from time to time, prescribe. Notice of such annual meeting date shall be sent to every affiliated county medical association at least sixty days before each annual meeting date so prescribed.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation in each year, every affiliated county association shall elect a delegate or delegates to represent it in The House of Delegates of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in The House of Delegates, one Councilor from each affiliated county medical association. The Councilors holding office at the time of the passage

of this act shall serve out the terms of office for which they were elected. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham, and Middlesex shall each elect one Councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield, and Tolland counties shall each elect one Councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a Councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 7. The secretary of each affiliated county medical association in this state, shall, within ten days following any meeting of such association at which new members are elected, file with the secretary of the society a list of all members of such association who are at the time in good and regular standing and thereupon all such persons shall become members of The Connecticut State Medical Society without further action.

BY-LAWS

ARTICLE I

NAME

Section 1. Name

Par. 1. The name of this organization shall be The Connecticut State Medical Society.

ARTICLE II

PURPOSES

Section 1. Purposes

Par. 1. The purposes of this Society shall be to federate and bring into one organization the medical profession of the State of Connecticut; to unite with similar society in other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standards of medical education; and to promote friendly intercourse among the physicians; to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease and in prolonging and adding comfort to life.

Par. 2. The Society is not organized, and shall never be maintained and conducted for the pecuniary profit of its members, officers, or employees but shall be, and remain, a strictly scientific and educational corporation, and no member, officer or employee of the Society shall at any time receive or be entitled to receive any pecuniary profit from the operation of the Society except a reasonable compensation for services actually rendered.

ARTICLE III

ETHICS

Section 1. Ethics

Par. 1. The Principles of Medical Ethics of the American

Medical Association shall govern the conduct of members in their relations to each other and to the public.

ARTICLE IV

COMPONENT ASSOCIATIONS

Section 1. Component Associations

Par. 1. The county medical associations in the following counties shall be the component associations of The Connecticut State Medical Society: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

ARTICLE V

MEMBERSHIP

Section 1. Membership

Par. 1. The Society shall consist of members, student members, associate members and honorary members.

Section 2. Members

Par. 1. All members in good standing in the component associations shall be members of this Society. Physicians whose names are on the official roster of membership of a component association shall be considered in good standing.

Section 3. Student Members

Par. 1. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 1662e of the General Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remuneration, may become Student Members of this Society.

Par. 2. Such membership shall be obtained by applying to the Council of the Society on a form provided for that purpose and election by vote of a majority of the Council.

Par. 3. Student Members shall enjoy all of the rights and privileges of membership in the Society except that they shall not be eligible to vote or hold office, and Student Members shall pay no dues.

Par. 4. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he shall be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

Section 4. Associate Members

Par. 1. Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut, may be elected as Associate Members in this Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file

with the Council a formal application for membership which shall be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the rights and privileges of the Society except that they may not vote or hold elective office; they may be appointed to serve upon committees and present papers before the Society or any of its sections.

Section 5. Honorary Members

Par. 1. Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article X, Section 3, Paragraph 4. They shall be accorded the privilege of participating in scientific work.

ARTICLE VI

OFFICERS

Section 1. Officers

Par. 1. The officers of this Society shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, an Executive Secretary, a Treasurer, the Managing Editor of the JOURNAL, a Speaker of the House of Delegates, a Vice-Speaker of the House of Delegates, the elected delegates to the American Medical Association, and a Councilor and Alternate Council elected from each component association.

Par. 2. The officers, except the President and the Councilors and Alternate Councilors, shall be nominated by the Nominating Committee and elected annually by ballot by the House of Delegates.

Par. 3. The President-Elect shall be elected annually. He shall serve as President-Elect until the annual session of the Society next ensuing after his election and shall become President upon his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor.

Par. 4. A Councilor and Alternate Councilor who shall serve for two years shall be elected at the annual meeting of each of the county associations in Hartford, New London, Windham, and Middlesex counties in the odd numbered years.

Par. 5. A Councilor and Alternate Councilor who shall serve for two years shall be elected at the annual meeting of each of the county associations in New Haven, Fairfield, Litchfield and Tolland counties in the even numbered years.

Par. 6. No Councilor or Alternate Councilor elected by a county association shall serve more than three successive terms of two years each in his respective office, but after a lapse of one term of two years such Councilor or Alternate Councilor may be eligible for re-election.

Par. 7. Any vacancy in the office of Councilor or Alternate Councilor shall be filled by the county association in which the vacancy occurs.

Section 2. Duties of Officers

Par. 1. The President shall preside at meetings of the Society, shall appoint all committees not otherwise provided for, shall visit the various medical associations throughout the state and shall present an annual address before the

Society at a time to be arranged by the Program Committee.

Par. 2. The duties of the President-Elect shall be to aid and assist the President.

Par. 3. The Vice-President shall assist the President in the discharge of his duties and in the absence of the President or upon his request shall assume the duties of the office. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the term by the First Vice-President. In the event of a vacancy in the office of President-Elect, the First Vice-President shall succeed to that office and the office of First Vice-President shall be assumed by the Second Vice-President.

Par. 4. The Executive Secretary shall attend the meetings of the House of Delegates, shall verify the eligibility and record the presence of members of the House of Delegates and keep minutes of its proceedings. He shall serve as secretary of the Council and keep a record of its proceedings. He shall provide for the registration of members and delegates at the annual sessions; he shall, with the cooperation of the secretaries of the component associations, keep a card index roster of all the legal practitioners of medicine in the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall cooperate with the officials of the county associations in the extension of the usefulness of the Society. He shall conduct official correspondence of the Society, notify members of meetings, officers of their election and committees of their appointment and duties. He shall make payment of necessary expenditures from funds allocated by the Treasurer and shall employ such assistance as may be approved by the Council. He may, upon request, supply each component association with the necessary blanks for application for membership and with blanks for making their annual reports. In cooperation with a Program Committee he shall publish and distribute all official programs.

Par. 5. The Treasurer shall receive all funds due the Society and shall receive bequests and donations on behalf of the Society. He shall remit periodically to the Executive Secretary and to the Editor of the JOURNAL prorated portions of the funds allocated to these officers for the operation of their offices. All other payments by him shall be subject to a written order of the Chairman of the Council, or in his absence, the President of the Society. The Treasurer shall give bond in a sum and manner of bonding prescribed by the Council. He shall make a report to the House of Delegates at the annual session.

Par. 6. The Managing Editor of the JOURNAL, in addition to the recognized duties of such an office, shall make payment of necessary expenditures from funds allocated to the JOURNAL by the Treasurer. His report of expenditures shall be included in the report of the Treasurer to the House of Delegates at its annual meeting.

Par. 7. The Speaker of the House of Delegates shall preside at all regular and special meetings of the House of Delegates except at such times as he may request the Vice-Speaker to preside during his temporary absence from the chair. He shall cooperate with the Executive Secretary and other officers of the Society in arranging the agenda for meetings of the House of Delegates and he shall appoint

reference committees as provided in Articles VII and VIII of the By-Laws, or as he may be directed by vote of the House. The Speaker of the House shall have the privilege of voting in the House of Delegates for the purpose of breaking a tie.

Par. 8. The Vice-Speaker of the House of Delegates shall assist the Speaker of the House of Delegates in the discharge of his duties and in the absence of the Speaker, or upon his request, shall assume the duties of his office. In the event a vacancy occurs in the office of Speaker of the House of Delegates, the Vice-Speaker shall succeed to that office until the next annual meeting of the Society.

Par. 9. In the event of a vacancy in the office of Executive Secretary, Treasurer, Managing Editor of the JOURNAL, Literary Editor of the JOURNAL, Vice-Speaker of the House of Delegates, the vacancy shall be filled by a member of the Society appointed by the Council to serve until the next annual or semi-annual meeting of the House of Delegates.

ARTICLE VII

MEETINGS

Section 1. Annual Meetings

Par. 1. The Society shall hold an Annual Session during which there shall be held scientific meetings which shall be open to all registered members and guests.

Par. 2. The time and place for holding each annual session shall be fixed by the Council.

Section 2. Special Meetings

Par. 1. Special meetings of the Society or House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Section 3. Recommendations

Par. 1. Recommendations made by any scientific session or section meeting may be submitted to the House of Delegates.

Section 4

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual or special meeting by the Council or resolutions and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of Paragraphs 1 and 2, of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates

present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference Committees shall consider the resolutions, and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

ARTICLE VIII

HOUSE OF DELEGATES

Section 1. House of Delegates

Par. 1. The House of Delegates shall be the legislative and business body of the Society and shall be empowered to carry out the purposes of the Society. It shall consist of the delegates elected by the component county associations and the members of the Council.

Par. 2. All past-presidents of the Society shall be ex officio members of the House of Delegates without the privilege of voting.

Par. 3. Each component association shall be entitled to send to the House of Delegates each year one delegate for every thirty-five members or any part of that number. A component county association with less than thirty-five members shall be entitled to one elected member of the House of Delegates.

Par. 4. The presiding officer of the House of Delegates may, in his discretion, appoint committees, to be known as reference committees, from the membership of the House to which business or reports presented before the House may be referred for review and recommendations.

Section 2. Duties

Par. 1. The House of Delegates shall elect delegates and alternate delegates from the Society to the House of Delegates of the American Medical Association in accordance with the constitution and by-laws of that body. These delegates and alternates shall take office on the first of January following their election and shall serve terms of two years.

Par. 2. The House of Delegates shall have authority to appoint committees for special purposes from among the members of the Society. Such committees shall make written reports through the Council to the House of Delegates, and members of these committees may attend meetings of the House of Delegates and participate in the discussion of reports submitted by them.

Par. 3. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections.

Par. 4. No memorial or resolution shall be issued in the name of the Society without first having been approved by the House of Delegates.

Section 3. Meetings

Par. 1. The Annual Meeting of the House of Delegates shall be called by the Council and shall be held during the week of the Annual Session of the Society. The order of business shall be arranged as a separate section of the program by the Council.

Par. 2. A Semi-Annual Meeting shall be held when re-

quired at a place and date to be set by the Council.

Par. 3. Special Meetings of the House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Par. 4. Twenty-five delegates shall constitute a quorum.

ARTICLE IX

THE COUNCIL

Section 1. Membership

Par. 1. The Council shall consist of one Councilor and one Alternate Council from each county association, the President, the President-Elect, the Executive Secretary, the Treasurer, the Managing Editor of the JOURNAL, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Delegates to the American Medical Association, any member of the Society who is currently serving as an officer of the American Medical Association, as provided in Article VII, Section 1, of the Constitution of the American Medical Association, and a Councilor-at-large, when elected, by the House of Delegates as provided in Paragraphs 2 and 3 of this section. Each member of the Council shall have one vote.

Par. 2. The Council may, in its discretion, recommend to the House of Delegates, at any annual meeting, the election to the Council for a term of one year of any member of the Society who is serving as a general officer of the American Medical Association as defined in Article VII, Section 1, of the Constitution of that Association.

Par. 3. The Council may, in its discretion, recommend to the House of Delegates, at any annual meeting, the election of a Councilor-at-large, who shall serve for a term of one year. Any member of the Society shall be eligible for nomination to the office of Councilor-at-large.

Section 2. Meetings

Par. 1. The Council shall meet at least every two months throughout the year, except during the months of July and August and September, and at such other times as a meeting may be called by the Chairman of the Council or upon petition of three members of the Council. It shall have its annual meeting for the purpose of organization and election of a Chairman at its first meeting following the annual meeting of the House of Delegates. Eight members of the Council which shall include four Councilors or Alternate Councilors elected by four county associations and four others, shall constitute a quorum for the transaction of business.

Section 3. Duties

Par. 1. The Council shall have the power to act for the House of Delegates between meetings of that body and shall report such actions to the House of Delegates at its next meeting.

Par. 2. The Chairman of the Council and the Councilor from each county shall be the Nominating Committee of the Society. The Chairman of the Council shall be the chairman of the committee. The committee, after consultation and advising with the entire Council, shall report its nominations to the first session of each annual meeting of the House of

Delegates. Following this report nominations may be made from the floor.

Par. 3. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or a general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken, and its decision in all such matters shall be final.

Par. 4. The Council shall serve as a board of review for cases of claimed malpractice referred to it by the Committee on Medical Ethics and Department of any component county association.

Par. 5. The Council shall be the finance committee of the Society and shall superintend and direct all financial transactions of the Society and shall prepare and submit annually to the House of Delegates a budget for the operation of the Society.

Par. 6. The Council shall make an annual report to the House of Delegates.

ARTICLE X

COMMITTEES

Section 1. Standing Committees

Par. 1. The Standing Committees of the Society shall be as follows:

- A Committee on Arrangements
- A Committee on Postgraduate Education
- An Editorial Board of the JOURNAL
- A Committee on Honorary Members and Degrees
- A Committee on Hospitals.
- A Committee on Industrial Health
- A Committee on Medical Education and Licensure
- A Program Committee
- A Committee on Public Health
- A Committee on State Legislation
- A Committee on Public Relations
- A Cancer Coordinating Committee
- A Committee on Professional Relations
- A Committee on Mental Health
- A Committee on Third Party Payments
- A Committee on Eye Care

Par. 2. Unless otherwise specified in these by-laws, nominations for these committees and their chairman shall be made by the Nominating Committee and presented to the Annual Meeting of the House of Delegates.

Par. 3. All standing and special committees, except the Committee on Arrangements, shall make a written report to the Council before the first of April of each year for transmittal with recommendations to the annual meeting of the House of Delegates. The Council, in its discretion, may request that any standing or special committee make a semi-annual report in writing to the Council for transmittal to the semi-annual meeting of the House of Delegates.

Section 2. Special Committees

Par. 1. Special committees may be appointed by the

Council or elected by the House of Delegates as may from time to time be required. Committees appointed by the Council shall make written reports to the Council as directed by it. Committees elected by the House of Delegates shall make written reports to the Council in the same manner as provided for standing committees.

Section 3. Duties of Committees

Par. 1. The Committee on Arrangements shall be appointed by the component association with which the annual session of the Society is to be held. It shall provide suitable accommodations for the meeting places of the Society, and of the special sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program.

Par. 2. The Nominating Committee shall nominate to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purposes of the committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society and to cooperate with university and other agencies within the state for the extension of postgraduate education of physicians.

Par. 3. The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL, consisting of not more than fifteen members. One of these shall be nominated as the Managing Editor of the JOURNAL and he shall be a member of the Council also. One other member of the Board shall be nominated as Literary Editor of the JOURNAL and he shall serve as Chairman of the Editorial Board. The Literary Editor, with the active participation and advice of other members of the Board, shall be responsible for the acceptance or rejection of manuscripts for publication and for their literary quality. He shall not be concerned with the business or financial aspects of the JOURNAL, which shall be the responsibility of the Managing Editor. The remaining members of the Editorial Board shall be selected so far as feasible, to represent the major divisions of medicine, surgery, pediatrics, obstetrics and psychiatry and consideration shall be given to representation from the geographic areas of the state. In addition to the Board so nominated, the President of the Society shall serve as an ex-officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

Par. 4. The Committee on Honorary Members and Degrees shall consist of the three latest past presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

Par. 5. The Nominating Committee shall nominate annu-

ally to the House of Delegates a Committee on Hospital to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

Par. 6. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into health in industry with the purpose of making information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

Par. 7. At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 4365 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

Par. 8. The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange the scientific program for the annual meeting of the Society, prepare such a program for submission to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Par. 9. The Nominating Committee shall nominate to the House of Delegates annually, one member from each

component county association and such additional members as it may determine not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society, in all matters pertaining to public health, sanitation, the prevention of communicable diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises recommend for the Society's consideration desirable legal enactments to promote public health within the state.

Par. 10. Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation. In addition to these eight members, the Committee shall include the delegates to the American Medical Association and the Executive Secretary, who shall serve as the executive officer of the Committee. The chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed state legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this state, appropriate legislation for improving medical care and the public health within the state, advising the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the state legislative field.

Par. 11. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members and nominate the chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and co-operate with other committees of the Society in a program of public relations.

Par. 12. The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee and nominate chairman thereof. The membership of this committee shall be not less than seven nor more than nine members and shall at all times include the president of the Connecticut Cancer Society, the chairman of the Connecticut Association of Tumor Clinics and a representative of the State Department of Health. The purpose of this committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut.

Par. 13. At its semi-annual meeting in 1950 each component county medical association shall elect a past president

of the association to serve on a state Committee on Professional Relations. The members so elected from the associations in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951 at which time the Hartford, New London, Windham, and Middlesex County Associations shall elect a past president to serve on the state Committee on Professional Relations for a period of two years and such elections shall be held biennially thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield, and Tolland shall serve until the annual meetings of these county associations in 1952 at which time the New Haven, Fairfield, Litchfield, and Tolland County Associations shall elect a past president to serve on the state Committee on Professional Relations for a period of two years and such elections shall be held biennially thereafter.

No member shall be elected to serve two consecutive terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except upon invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional malpractice or negligence. The purposes of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and, (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society's Secretary, either from the public or other physicians, they will be referred at once to the secretary of a county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with that county association. If in the judgment of the appropriate committee of the county association the complaint should be heard by the state Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee representing the county association, to which a physician against whom charges have been brought belongs, shall not vote on the final conclusions reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arrival at a decision, shall notify the physician, against whom charges have been brought (by registered mail) of its findings and disciplinary action to be taken and at the same time, file a resume of its findings and action with the secretary of the county association to which the physician belongs and with the Council of the State Medical Society. A member disciplined

by the action of this Committee shall have the right of appeal to the Council before the expiration of 15 days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

Par. 14. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. This Committee shall be continually informed concerning the provisions for the care of the mentally ill in the state and those addicted to the use of habit-forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this state so afflicted.

Par. 15. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Third Party Payments to consist of five members and nominate the chairman thereof. The function of this Committee shall be to study existing and projected systems providing payment for physicians' services by any public, private, or cooperative agency, and to advise the Society concerning them. In its operations, the Committee shall confer with representatives of such agencies and other committees of the Society having interest and responsibility in specific phases of medical care that involve payment of physicians by third party agencies.

Par. 16. The Nominating Committee shall nominate annually to the House of Delegates a Committee on Eye Care and nominate the chairman thereof. The membership of this committee shall be not more than fifteen members and shall include at least four but not more than seven members of the Executive Committee of the Eye, Ear, Nose and Throat Section and shall include the advisors from the Society to the Public Relations Committee of the American Medical Association, Section on Ophthalmology. The purpose of this committee shall be to coordinate and integrate the efforts of various agencies whose functions may include some phase of eye care, to cooperate with other committees of the Society in the eye care phases of their activities, and to cooperate with the AMA committees concerned with the promotion of eye care. The Committee shall develop and make available to members of the Society and all other persons interested in improving eye care, information on all phases of eye care. The Committee shall also, as occasion arises, recommend for the Society's consideration desirable legislative enactments to promote improvements in eye care within the state.

ARTICLE XI

FUNDS AND EXPENSES

Section 1. Funds

Par. 1. Funds for the operation of the Society shall be raised by an equal annual per capita assessment from each member of a component county association, except:

Par. 2. Members who are elected to the county associations at the semi-annual meetings will be assessed one-half of the annual dues for the year of their election.

Par. 3. Members who have been in good standing in the

Society for 40 consecutive years or who have attained the age of 68 and have been members of the Society for 15 years immediately preceding shall be exempt from further payment of dues upon written request addressed to the Treasurer of the Society by the Secretary of the County Association in which the physician seeking exemption is a member and shall continue as active members of the Society enjoying all rights and privileges.

Par. 4. The dues of any member may be remitted by vote of the Council on recommendation of a County Councilor or Alternate Councilor.

Par. 5. All funds of the Society shall be deposited promptly upon receipt in a state or national bank located in the State of Connecticut.

Par. 6. The fiscal year of the Society shall commence on January 1 and terminate on December 31 of each year.

Section 2. Budget

Par. 1. The annual budget of the Society shall be prepared by the Council, as the Finance Committee of the Society, and be presented to the House of Delegates for approval. Based upon that budget the Council shall recommend to the House of Delegates the amount of per capita assessment for the ensuing fiscal year. All requests and resolutions appropriating funds of the Society shall be referred to the Council for recommendation to the House of Delegates and all such requests and recommendations must be approved by the House of Delegates before funds may be expended.

Section 3. Fidelity Bonds

Par. 1. The Council shall prescribe and provide at the expense of the Society proper fidelity bonds for officers of the Society and other persons responsible for the receipt, custody and disbursement of funds belonging to the Society.

ARTICLE XII

REFERENDUM

Section 1. Referendum

Par. 1. A general meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such questions to the members of the Society who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Par. 2. The House of Delegates may, by a two-thirds vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII

COMPONENT COUNTY ASSOCIATIONS

Section 1. Component County Associations

Par. 1. The County Medical Associations in Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham Counties now in operation and in

affiliation with The Connecticut State Medical Society shall be the component county associations, of this Society.

Section 2. Function

Par. 1. The function of the component medical associations shall be to bring together into one organization the physicians of each county and these associations shall be united for the purpose of organizing the medical profession in the State of Connecticut as provided in Article II, Section 1, of these By-Laws.

Section 3. Eligibility for Membership

Par. 1. All registered physicians licensed under Section 1660c of the General Statutes of the State of Connecticut, 1930, as amended, shall be eligible to apply for membership.

Section 4. Application for Membership

Par. 1. A physician who desires to become a member of a county medical association shall obtain from the Secretary of that association an application form which, when completed, shall be returned to the Secretary. A physician living near a county line may hold membership in that county most convenient for him on permission of the association in whose jurisdiction he resides.

Section 5. Transfer of Membership

Par. 1. A member of a component association of the Society who removes his residence to another county within this state and who wishes to transfer his membership to the county association in the county of his new residence may do so upon the presentation of a certificate signed by the Secretary of the county association of which he is a member. This certificate shall state that he is a member in good standing in the association of the county where he previously resided and that his financial obligations to that association for the current year have been paid. The certificate shall be accompanied by a regular application for membership. The association in the county of his new residence shall add him to the rolls of that association without formality and without charging any dues for the remainder of the year of his transfer.

Par. 2. A member of a state medical society in another state, that is a component of the American Medical Association, wishing to transfer his membership to a component county association of this Society shall present to the Secretary of the component association of this Society in which he is seeking membership a certificate from the Secretary of the county or state medical society of his previous residence. This certificate shall state that he is a member in good standing in that county or state medical association. This certificate and a properly completed application for membership shall be forwarded to the Board of Censors or Credentials Committee of the component association in this state in which he is seeking membership and that Board of Censors or Committee on Credentials may recommend his election at the next meeting of the component association.

Section 6. Membership Roster

Par. 1. The Secretary of each component association shall keep an individual record of the members of that association, and this record shall include the full name,

address, college degrees with year, medical schools attended with school and year of graduation, hospital affiliations, type of special practice, if any, and date of registration in this state. Notations shall also be made concerning transfer and termination of membership.

Section 7. Discipline

Par. 1. Any member of a component county association who is aggrieved by disciplinary action of the county association of which he is a member shall have the privilege of appealing to the Council of the Society which shall review the charges made against the disciplined member and the findings therein and render a decision concerning the disciplinary action taken; this shall be final.

Section 8. Termination of Membership

Par. 1. When membership in a component county association terminates for any cause, membership in the Connecticut State Medical Society shall be terminated automatically as of the same date.

Section 9. Delegates to the House of Delegates of the Society

Par. 1. Each component county association shall be represented in the House of Delegates of the Society on the basis of one delegate for each thirty-five members and any part of that number. Component associations with less than thirty-five members shall be entitled to one elected delegate.

Par. 2. On or about the 15th of March of each year the Executive Secretary of the Society shall inform the Secretary of each of the component associations of the number of members in good standing in each component association on the 31st of December just preceding, and compute therefrom the number of delegates to which each county association is entitled for the ensuing year.

Par. 3. At least twenty days prior to the annual meeting of the House of Delegates the Secretary of each component association shall inform the Executive Secretary of the Society of the names and addresses of the officially elected and qualified delegates from each county association.

Par. 4. In case of the inability of a regularly elected delegate to attend meetings of the House of Delegates, the President or the Secretary of the county association in which the vacancy occurs shall appoint an alternate delegate, with full power to represent that county association during the interim, or until the successor of such regularly elected delegate is elected. Upon the appointment of such alternate delegate, the Secretary of the county association in which the appointment is made shall inform the Executive Secretary of the Society of the appointment at once, and before the alternate delegate may be seated in the House of Delegates.

Section 10. Dues

Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to all members immediately following January 1 of each year and the component county associations shall forward all monies

so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In that event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed with the county association before the 15th of January of each year.

Section 11. By-Laws

Par. 1. The component county associations shall have the power to adopt only such by-laws as are not in conflict with the by-laws of The Connecticut State Medical Society. In the event of an existing or apparent conflict the by-laws of the Society shall take precedence over those of a component county association.

ARTICLE XIV

AMENDMENTS

Section 1. Amendments

Par. 1. The by-laws of the Society may be amended by a majority vote of the total number of the members of the House of Delegates.

Par. 2. Proposed amendments to the by-laws shall be submitted first to the Council and published with the Council's recommendation, in the CONNECTICUT STATE MEDICAL JOURNAL at least one month prior to the date of the meeting of the House of Delegates at which action thereon is to be taken. Copies of the proposed amendments shall also be forwarded to each member of the House of Delegates in the notices of the meeting at which the amendments are to be acted upon.

ARTICLE XV

PARLIAMENTARY PROCEDURE

Section 1. Rules of Order

Par. 1. In all matters of parliamentary procedure the Society shall be governed by Robert's Rules of Order.

Section 2. Enablement Clause

Par. 1. The adoption of these by-laws rescinds and revokes all previous by-laws of the Society and supercedes their operation.

PHYSICIANS AND PSYCHIATRISTS FOR CALIFORNIA STATE. STREAMLINED EMPLOYMENT PROCEDURE: By interview only (no written examinations). Interviews held periodically in California and nationwide. Wide choice of positions in 15 large State hospitals, institutions, and veterans home. 40 hour week, liberal vacation, and other benefits including generous retirement annuities. Annual salary increases. Three salary groups: \$10,860 to \$12,000; \$11,400 to \$12,600; \$12,600 to \$13,800. Candidates must be U. S. citizens and in possession of, or eligible for, California license. For full information write to Miss Carmack, Supervisor, Medical Recruiting, Box A, State Personnel Board, 801 Capitol Avenue, Sacramento, California.



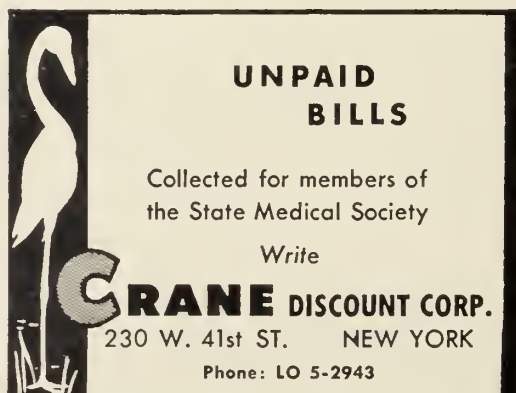
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Acetylsalicylic Acid (2½ gr.)	162.0 mg.
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Prophepyridamine Maleate	12.5 mg.
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Collected for members of
the State Medical Society

Write
CRANE DISCOUNT CORP.
230 W. 41st ST. NEW YORK
Phone: LO 5-2943

413949
The Dependents' Medical Care Act
(Public Act 569, 84th Congress)



MEDICARE

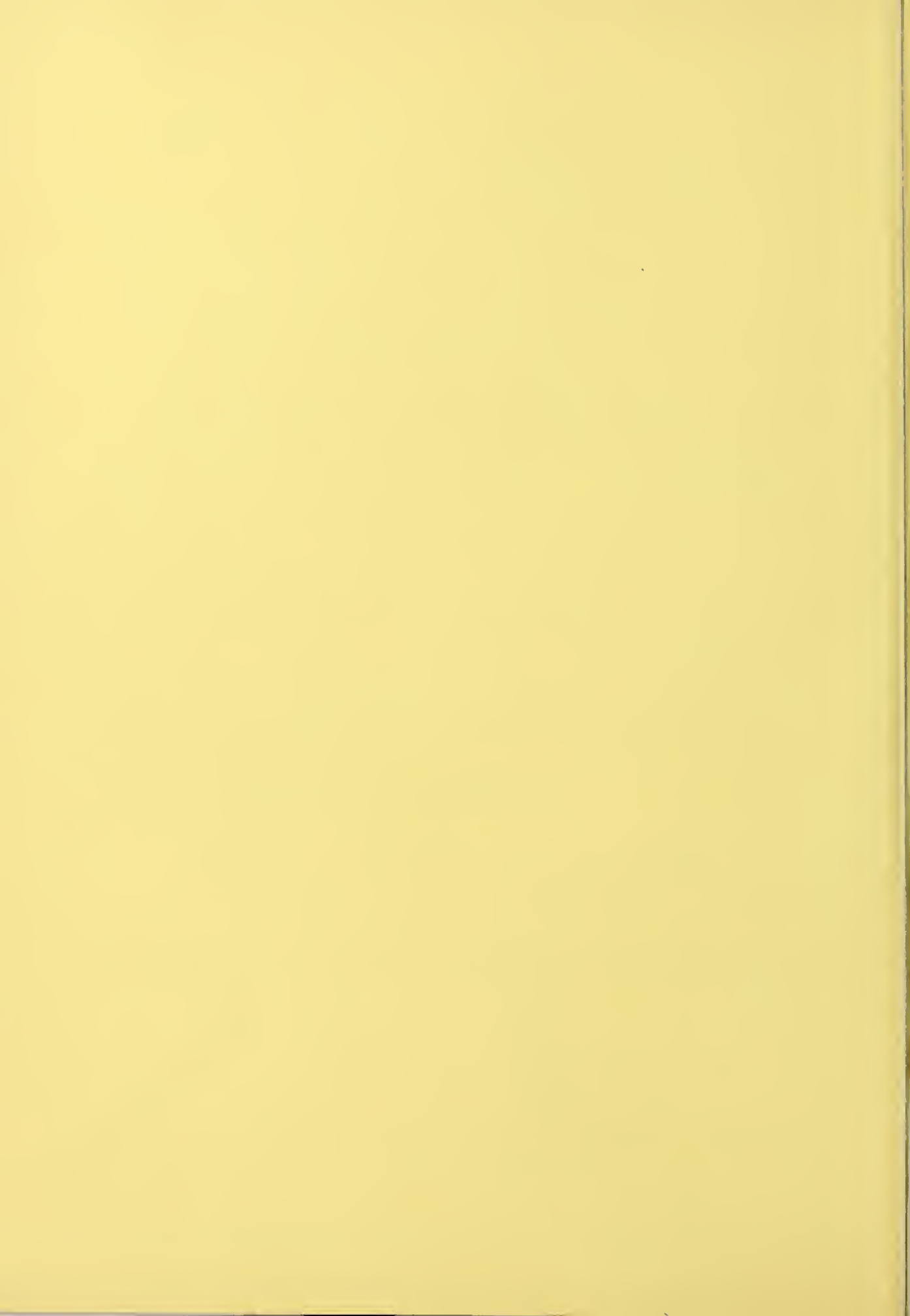
CONNECTICUT

Schedule of Allowances for Physicians Fees

Connecticut State Medical Society

February 1957

Supplement to Connecticut State Medical Journal
Volume XXI, No. 2



THE DEPENDENTS' MEDICAL CARE ACT
(Public Act 569, 84th Congress)

MEDICARE
in
CONNECTICUT

The Dependents' Medical Care Act passed by the 84th Congress is administered in Connecticut by the Connecticut State Medical Society under contract with the Department of Defense. All matters relating to professional policies and the Schedule of Allowances are determined by the MEDICARE Committee of the Society subject to approval by the Council and the House of Delegates. Inquiries in connection with these matters should be directed to the Connecticut State Medical Society, 160 St. Ronan Street, New Haven, Telephone New Haven UNiversity 5-0587.

Connecticut Medical Service is also under contract with the Department of Defense as Fiscal Administrator. Claims will be processed by the Special MEDICARE Division of Connecticut Medical Service. Physician's claims for professional services should be filed in duplicate on form DA 1863 (or its successor) and mailed to MEDICARE, P. O. Box 755, New Haven. Inquiries regarding claims should be directed to that address or telephone New Haven, LOcust 2-5191.

MEDICARE COMMITTEE
of the
Connecticut State Medical Society

Thomas J. Danaher	Litchfield County	Surgery, Chairman
Hugh K. Miller	Fairfield County	Obstetrics-Gynecology
John E. Cartland, Jr.	Hartford County	Pediatrics
Harold M. Clarke	Hartford County	Surgery
Willard E. Buckley	Middlesex County	Radiology
Hugh L. Dwyer	New Haven County	Internal Medicine
Richard B. Elgosin	New Haven County	General Medicine
Henry A. Archambault	New London County	Surgery
R. Bruce Thayer, Jr.	Tolland County	General Medicine
Morton Arnold	Windham County	Eye, Ear, Nose and Throat

Co-ordinator
Creighton Barker, M.D., 160 St. Ronan Street, New Haven, Connecticut

Connecticut Medical Service
William H. Horton, M.D., Executive Director

OFFICE FOR DEPENDENTS' MEDICAL CARE
OFFICE OF THE SURGEON GENERAL
DEPARTMENT OF ARMY — WASHINGTON, D. C.

INTRODUCTION

This pamphlet has been prepared by the Department of Defense and the Department of Health, Education, and Welfare. Its purpose is to assist all individuals of the United States and the Territories concerned with the processing of claims for remuneration of services rendered, arising out of the Dependents' Medical Care Act, Public Law 569, 84th Congress. Persons eligible for care under this program are dependents of active duty members of the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned members of the United States Public Health Service, and Commissioned members of the Coast and Geodetic Survey.

This pamphlet, together with the appropriate published price supplement, constitutes the Schedule of Allowances for Physicians' Fees authorized under the Dependents' Medical Care Act. The fees listed reflect the maximum fee allowable for any given procedure. Payments made within this maximum fee constitute payment in full for authorized services rendered.

In view of the full payment concept, the Government does not intend that the dependent pay more than the nominal charges stipulated by the Government. Consequently, patients are being encouraged to ascertain that the physician they contact is willing to provide services within the published Schedule of Allowances. Likewise, physicians who will be providing authorized care to eligible dependents under this program are urged to assure themselves that the dependent is properly identified in order that certification can be made accurately that services were provided in accordance with the Dependents' Medical Care Act.

In order to obtain the necessary statistical and actuarial data and to provide uniformity in the description of the medical services rendered, a Uniform Nomenclature and a Standardized Code System has been developed to meet this vital need.

The code numbers and the nomenclature used in this publication have been taken from those in common use and created principally by Blue Shield and Blue Cross.

The code numbers and nomenclature published herein must be rigidly adhered to in reporting the services.

Cooperation of all concerned in correctly preparing reports will be appreciated and will speed the processing of claims.

PAUL I. ROBINSON
Major General, M. C.
Executive Director
Office for Dependents' Medical Care

FOREWORD

THE "DEPENDENTS' MEDICAL CARE ACT"

PUBLIC LAW 569, 84TH CONGRESS

I. *The Purpose of the Act is—*

"To create and maintain high morale throughout the uniformed services by providing an improved and uniform program of medical care for members of the uniformed services and their dependents."

II. *The Act Provides for the Accomplishment of this Purpose By:*

1. Recognizing by statute the importance of this traditional benefit and the entitlement of service members and their dependents to medical care.
2. Continuing the practice of providing medical care to dependents and retired personnel at service medical facilities.
3. Permitting dependents and retired personnel of all the uniformed services to obtain available medical care at any medical facility of the Army, Navy, Air Force or Public Health Service.
4. Requiring the establishment of a system of providing medical care through civilian medical facilities for those spouses and children of active duty personnel who do not have access to service medical facilities.

EXPLANATION OF DEPENDENTS' MEDICAL CARE ACT OF 1956 (P.L. 569—84th Congress)

UNDER THE PROVISIONS OF THE DEPENDENTS' MEDICAL CARE ACT, dependent spouses and children of members of the Uniformed Services (Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and Coast and Geodetic Survey) *on active duty or active duty for training under orders not specifying a period of thirty days or less* are eligible to receive certain medical care from civilian sources at Government expense.

DETAILED INFORMATION concerning the kinds of medical care and the circumstances under which this medical care is authorized to be obtained and paid for at Government expense is available at activities of the Uniformed Services.

MEDICAL SERVICES AUTHORIZED to be provided eligible spouses and children may include:

- a. Hospitalization in semi-private accommodations up to 365 days for each admission, including all necessary services and supplies furnished by the hospital during hospitalization.
- b. Medical and surgical care during a period of hospitalization.
- c. Complete obstetrical and maternity care. Normally the Government restricts payment to one physician within any one trimester of maternity care or for postpartum care. Exceptions may be granted in cases wherein a change of physician was necessitated by circumstances beyond the control of the patient, i.e., permanent change of sponsor's duty station; change of patient's residence involving a considerable distance; death or disability of physician.
- d. Services required of a physician prior to and following hospitalization for a bodily injury or surgical operation. Patient will normally pay charges for diagnostic test in excess of \$75 prior to hospitalization and in excess of \$50 following hospitalization.
- e. Diagnostic test and procedures, including laboratory, pathology, and x-ray examination during

hospitalization when ordered by the attending physician.

f. Treatment of fractures, dislocation, lacerations and other wounds when patient is NOT hospitalized. Patient will normally pay the first \$15 of such physician fee plus cost of diagnostic test, in excess of \$75.

g. Treatment in a hospital of acute emergencies of any nature which are a threat to the life, health, or well-being, of the patient including acute emotional disorders pending arrangement for care elsewhere.

h. Dental care which is a necessary adjunct to medical or surgical treatment rendered in a hospital to a dependent who is a hospital inpatient and concurred in by the attending physician.

IV. MEDICAL SERVICES NOT AUTHORIZED from civilian sources include:

- a. Chronic diseases, except for acute exacerbations or acute complications.
- b. Nervous and mental disorders. i.e., neuroses, psychoneuroses, psychopathoses or psychoses (except in III g above).
- c. Elective medical and surgical treatment desired by the patient which in the opinion of cognizant medical authority is not medically indicated.
- d. Domiciliary type care, e.g. personal care contradistinct to active and definitive treatment.
- e. Outpatient care except for the payment of one visit to a physician initially responsible who transfers full care to another physician upon patient's hospitalization and as indicated in III above.
- f. Ambulance service.

V. PAYMENT FOR CIVILIAN MEDICAL CARE BY PATIENT OR SPONSOR: The patient, or sponsor, will pay directly to the civilian medical facility such portion of the medical expenses as are prescribed jointly by the Secretary of Defense and the Secretary of Health, Education, and Welfare. This includes generally that the patient or sponsor will pay directly to the civilian medical facility the sum of \$25 or an amount determined by multiplying the number of days hospitalized by \$1.75, whichever sum is greater.

MEDICAL SERVICES

Visits and Examinations

0002	Hospital visit.....	First day 15.00
		Second day 10.00
	Each day thereafter, if visit made	5.00
0006	Follow-up office visit Neonatal Care, first 60 days (not more than two visits).....	5.00
0007	Follow-up home visit Neonatal Care, first 60 days (not more than two visits).....	5.00
0009	Hospital care of premature infant.....	First day 15.00
		Second day 10.00
	Each day thereafter, if visit made	5.00
	Neonatal care of Infant during first sixty (60) days after delivery.	
0010	Hospital, home or office visit (first call—routine history and necessary examination)	10.00

SPECIAL MEDICAL PROCEDURES

The following items may be used by all physicians, but are included in the schedule to be used in cases which appear to be of a serious or complicated nature requiring additional time and special study.

In addition to the allowances listed below, in instances in which a medical case requires an unusual amount of the physician's time on the first day of hospitalization, reasonable charges in excess of the hospital visit charge may be authorized by the contracting officer, upon submission of a special report in accordance with the provisions of the Contract.

0026	Consultation for given system not requiring complete examination	15.00
0027	Consultation requiring complete examination—Office hospital or home.....	25.00
0032	Prolonged detention with patient in critical condition per hour	20.00
0033	Hospital visit necessitating professional care over and above routine hospital visit.....	20.00 per hour
0011	Home or Office Visit (not more than one (1), for Physician terminating his professional care of patient at time of patient's hospitalization).....	10.00

Allergy Testing

Allergy test as an aid in the diagnosis of disease states is read and interpreted by a physician, authorized only when related to the cause of admission.

Unit Fee by Type and Number of Tests Performed. (This includes the observation of the tests.)

0035	Scratch or puncture tests, per ten tests.....	5.00
0036	Intradermal tests, per ten tests.....	6.00
0037	Patch tests, per one test.....	1.00
0038	Direct ophthalmic tests, per one test.....	2.00
0039	Direct nasal test, per one test.....	2.00
0040	Passive transfer tests, per ten tests.....	15.00

SURGERY

GENERAL INFORMATION

Fee for Surgery only. Including care prior to hospitalization and ordinary after care.

In multiple surgical procedures performed through the same incision, payment will only be made for the major procedure, except by special report.

In multiple surgical procedures, in remote operative fields and separate incisions, an additional 50 per cent of the minor fee will be paid unless otherwise specified in the fee schedule.

Bilateral procedures in separate operative fields will be allowed an additional 50 per cent unless otherwise specified in the fee schedule.

Procedures not specifically listed will be given a fee comparable to the listed procedure of closest similarity upon written report.

Two physicians may not be paid for attendance on the same case at the same time except where it is warranted by the necessity of supplementary skills. Separate fees will be paid for an assistant(s) who is authorized by the attending physician to assist in surgical procedures specified in the schedule of allowances. Such assistant(s) fees will be 20% of the fee allowed the surgeon for the specific operation performed. This 20% allowance to the assistant(s) will be in addition to the fee paid to the surgeon. Assistant(s) fees will not be paid to physicians in training (residents, etc.).

Values for x-ray and laboratory procedures are listed elsewhere in this schedule.

Allowances for surgical procedures performed by a physician for a dependent who, at the time, is not an inpatient in a hospital will be limited to the treatment of fractures, dislocations, lacerations and other wounds and the allowances for such procedures will be in accordance with the pertinent amounts included in this Schedule of Allowances. Outpatient type care in addition to the foregoing, authorized at government expense is limited to obstetrical care, and such other care as authorized in the Joint Directive.

The designation S/R after an item signifies that a Special Report of the procedure must be submitted with the claim form DA 1863 filed by the physician. Based on information contained in this Special Report, an appropriate fee for the service will be determined by the Medicare Committee of the Connecticut State Medical Society.

Integumentary System

SKIN AND SUBCUTANEOUS AREOLAR TISSUE

Incision

0101	Drainage of infected steatoma.....	20.00
0102	Drainage of furuncle.....	20.00
0108	Drainage of carbuncle.....	35.00
0114	Drainage of subcutaneous abscess (where not specified elsewhere)	50.00
0115	Drainage of pilonidal cyst.....	40.00

0125	Drainage of onychia or paronychia, with or without complete or partial evulsion of nail.....	20.00
0130	Incision and removal of foreign body, subcutaneous tissues, simple.....	30.00
0131	Incision and removal of foreign body, complicated....	S/R
0140	Drainage of hematoma.....	20.00
0145	Puncture aspiration of abscess or hematoma.....	10.00

Excision

0171	Biopsy of skin or subcutaneous tissue.....	10.00
0190	Wide excision of lesion; without graft or plastic closure	45.00
0191	with graft or plastic closure (see 0275 to 0319)	
0215	Lipectomy (see 0260 to 0262)	
0230	Excision of nail, nail bed or nail fold, partial.....	20.00
0231	complete	40.00
0238	Excision of pilonidal cyst or sinus.....	90.00
0240	Excision of hidradenitis suppurativa (see 0260 to 0319)	
0242	Excision of post-phlebitic varicose ulcer with graft (independent procedure) (see 0260 to 0319)	
0245	Resection of malignant lesion, small (see 0260 to 0319)	

Repair—Plastic Surgery

The following values are for procedures carried out on trunk areas and include creation of the defect and its repair. To obtain the values of the same procedures carried out elsewhere on the body, where greater degrees of skill, effort and time are necessary, multiply these base values by following factors:

	(a) scalp, arms, legs—1½ times base.	
	(b) forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands, feet—2 times base.	
	(c) eyelids, nose, ears, and lips—2½ times base.	
0260	Local excision and/or direct repair of essentially round neoplastic, cicatricial, inflammatory or congenital lesion up to ½ inch in diameter.....	S/R
0261	½ to ¾ inch in diameter.....	S/R
0262	over ¾ inch in diameter.....	S/R
0265	Excision and/or direct repair, linear scar or wound up to ½ inch wide and ½ inch long.....	S/R
0266	each additional ½ inch.....	S/R
0267	Excision and/or direct repair of other linear lesions or wounds (wider, deeper, etc.) unless specified elsewhere	S/R
0275	Excision and/or repair by Z-plastic, rotation flap, advanced flap, double pedicle flap, or other rearrangement and suturing of adjacent tissues, small.....	S/R
0276	large	S/R

GRAFTS—List area of skin transferred, location of defect, type and size of graft, and age of patient. Fee includes creation and surgical preparation of defect and placing of graft.

0288	Skin grafts, pinch or split skin, less than 2 square inches	S/R
0289	pinch or split skin, 2 to 32 square inches.....	S/R
0291	each additional 32 square inches or part thereof at same procedure.....	S/R
0295	free full thickness, up to 3 square inches.....	S/R
0296	each additional 3 square inches or part thereof at same procedure.....	S/R
0297	requiring skin graft of local flaps to repair donor site (use multiple procedure formula).	
0309	direct flap or tube pedicle transplantation, initial stage	S/R
0310	delay, intermediate transfer, or detachment of pedicle or tube graft.....	S/R
0311	excision of lesion or preparation of recipient site and attachment of tube or pedicle graft.....	S/R

0312	revision, defatting or rearrangement of transferred skin graft (see 0260 to 0276, incl.).	
0319	Composite graft (full thickness of external ear or nasal ala)	S/R
0325	Derma-Fat-Fascia-Graft	50.00

BURNS—List percentage of body surface involved, location of involved areas, age of patient. (Does not include skin grafts.)

0351	Initial treatment, first degree, where no more than local treatment necessary.....	10.00
0352	Dressings, initial or subsequent under anesthesia, small	10.00
0353	under anesthesia, large or with major debridement, per hour	25.00
0354	without anesthesia, small, office or hospital.....	5.00
0355	without anesthesia, medium (whole face or whole extremity, etc.).....	10.00
0356	without anesthesia, large (more than one extremity, etc.)	20.00

BREAST

Incision

0431	Mastotomy with exploration, or drainage of abscess—deep	45.00
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Excision

0441	Biopsy of breast.....	25.00
0445	Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple (including any other partial mastectomy), unilateral	50.00
0446	Excision of chest wall tumor involving ribs.....	115.00
0447	Excision of chest wall tumor involving ribs plus plastic reconstruction	200.00
0451	Excision of cyst, etc., bilateral.....	75.00
0457	Complete (simple) mastectomy.....	100.00
0470	Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes.....	200.00

Musculoskeletal System

BONES

These fees include the application of first cast or traction device.

Incision

0501	Aspiration biopsy of bone marrow, including sternal puncture	15.00
0506	Incision of soft tissue, abscess from osteomyelitis....	50.00
0513	Sequestrectomy for osteomyelitis or bone abscess, superficial	S/R
0516	Removal of metal band, plate, screw or nail (independent procedure)	35.00

OSTEOTOMY—Cutting, division or transection of bone, with or without internal fixation.

0526	Clavicle	75.00
0527	Humerus	200.00
0530	Radius (malunited Colles' fracture).....	150.00
0531	Ulna	100.00
0532	Femur, subtrochanteric	225.00
0534	Femur, supracondylar	225.00
0536	Tibia	200.00
0537	Lesser bones	100.00
0538	Correction of bowlegs or knock-knees, bilateral....	200.00
0539	unilateral	200.00

Excision

0550	Biopsy bone, superficial.....	25.00
0551	deep	50.00
0552	Claviclectomy, partial	75.00
0553	total	125.00
0554	Astragalectomy	125.00
0556	Excision of head of radius.....	75.00
0557	Carpectomy, one bone.....	75.00
0560	Coccygectomy	75.00
0561	Patellectomy or hemipatellectomy.....	150.00
0563	Metatarsectomy	75.00
0565	Excision of bone marrow.....	15.00
0566	Excision of bone cyst, chrondroma, or exostosis, large bones	125.00
0567	small bones	50.00
0576	Partial ostectomy; partial excision of bone; craterization, guttering or saucerization of bone; diaphysectomy—femur, tibia, humerus, radius, fibula, etc.	S/R
0577	lesser bones	50.00
0580	Radical resection of bone for tumor with bone graft, major bone	S/R
0581	minor bone	S/R

Introduction (independent procedure only; for associated procedures, see Fractures).

0591	Insertion of wire (Kirschner wire).....	25.00
0593	Insertion of metal pin (Steinmann pin).....	25.00
0595	Insertion of caliper or tongs.....	25.00
0597	Insertion of threaded or beaded wire.....	25.00

Repair

0611	Osteoplasty: shortening of bone, femur, tibia, humerus..S/R	
0612	shortening of bone, radius, ulna.....	S/R
0613	other bones	S/R
0614	lengthening of bone.....	S/R

BONE GRAFT—Osteoperiosteal graft; periosteal graft. Includes obtaining and placing of graft.

0617	Bone graft: femur, tibia, humerus.....	S/R
0618	radius, ulna	S/R
0619	autogenous, to face or skull (including taking and placing)	S/R
0620	other bones	S/R
0621	Cartilage graft, autogenous, to face or skull (including taking and placing graft).....	S/R
0622	Bone or cartilage graft, non-autogenous, or heterologous graft, to face or skull (including preparing and placing material)	S/R
0634	Spinal fusion with partial excision of intervertebral disk (see Joints—Excision—1075 to 1076).	
0635	Spinal fusion, more than two segments.....	200.00
0642	Lumbosacral fusion	200.00
0645	Scapulopexy	100.00
0648	Patellapexy	125.00
0649	Pectus excavatum—infants—plastic repair.....	125.00
0650	Pectus excavatum (major) plastic repair.....	250.00
0654	Epiphyseal-diaphyseal fusion; epiphyseal arrest; epiphyseal diaphyseal fusion, femur	125.00
0655	tibia and fibula.....	125.00
0656	combined (femur, tibia and fibula).....	200.00
0657	combined (upper and lower tibial and fibular).....	200.00
0667	Freeing of bone adhesions, callus or synostosis (independent procedure) (see Osteotomy).	

FRACTURES

Manipulation

0681	Skull, non-operative, in hospital.....	
0683	depressed with operation.....	125.00

Facial Bones

0686	Nasal, simple, closed reduction.....	30
0687	compound, closed reduction.....	85
0688	simple or compound, open reduction.....	85
0691	Malar, simple, closed reduction.....	35
0693	Malar, simple or compound, depressed, open reduction	90
0694	multiple surgical approaches.....	125
0696	Maxilla, simple, closed reduction.....	35
0699	Maxilla, simple or compound, closed reduction, wiring of teeth.....	125
0701	simple or compound, open reduction, with wiring of teeth or local fixation.....	150
0702	multiple, simple or compound, complicated, open reduction, and fixation by traction, head caps, multiple internal fixation, etc.	125
0703	Mandible, simple, closed reduction.....	35
0704	Mandible, simple or compound, closed reduction wiring of teeth.....	150
0705	simple or compound, open reduction.....	150
0706	skeletal pinning with external fixation.....	150

Spine and Trunk

0720	Vertebral body, closed reduction, one.....	140
0721	more than one.....	210
0732	Sacrum, compound	40
0733	simple or compound, with operation.....	S
0740	Clavicle, simple, closed reduction.....	35
0741	compound	35
0742	simple or compound, open reduction.....	75
0747	Scapula, simple, closed reduction.....	40
0752	plus acromial process, simple, closed reduction.....	75
0753	compound	40
0754	simple or compound, open reduction.....	150
0756	Sternum, simple, non-depressed, closed reduction.....	35
0757	compound	35
0761	Ribs, simple, strapping.....	15.00 for c
		10.00 each addition
		35.00 multiple m
0762	complicated	S

Pelvis (Ilium, Ischium, Pubis)

0767	Fracture, simple, closed reduction.....	75
0768	complicated, closed reduction.....	S
0770	one or more bones, compound.....	110
0771	one or more bones, simple or compound, open reduction	200
0772	Acetabulum, with or without other fractures of pelvis	
	simple, closed reduction, no displacement.....	100
0773	central, with displacement.....	100
0774	compound	100
0775	simple or compound, open reduction.....	200

Upper Extremity

0778	Humerus, surgical neck, simple, not requiring manipulation	67
0780	surgical neck, simple, requiring manipulation with anesthesia	100
	compound	100
0781	simple or compound, open reduction.....	200
0782	shaft, simple, closed reduction.....	100
0784	simple, closed reduction with anesthesia.....	100
0785	simple or compound, open reduction.....	200
0787	skeletal pinning with external fixation.....	100
0791	Elbow (distal end of humerus, proximal end of radius, proximal end of ulna) condyle only, simple, closed reduction	100
0792	one or more bones, simple, closed reduction.....	100

0793	one or more bones, compound.....	100.00	0907	malleolus, simple, closed reduction.....	50.00
0794	one or more bones, simple or compound, open reduction	200.00	0910	simple or compound, open reduction.....	100.00
0795	skeletal pinning with external fixation.....	100.00	0914	Fibula, shaft, simple, closed reduction.....	35.00
0796	supracondylar	100.00	0916	simple or compound, open reduction.....	70.00
0797	olecranon, open reduction.....	200.00	0920	malleolus, simple, closed reduction.....	50.00
0798	Radius, head, simple, closed reduction.....	50.00	0922	simple or compound, open reduction.....	100.00
0800	head, compound	75.00	0926	Tibia and fibula, shafts, simple, closed reduction....	100.00
0801	simple, or compound, open reduction.....	150.00	0927	compound with anesthesia.....	100.00
0802	shaft, simple, closed reduction, without displacement	34.00	0928	simple or compound, open reduction.....	200.00
0803	simple, closed reduction, with displacement.....	50.00	0930	skeletal pinning with external fixation.....	100.00
0804	compound	50.00	0933	Ankle, bimalleolar (including Potts) simple, closed reduction	100.00
0805	simple or compound, open reduction.....	100.00	0934	compound, with anesthesia.....	100.00
0807	distal end, Colles' (including ulnar styloid) simple, closed reduction	75.00	0935	simple or compound, open reduction.....	200.00
0810	simple or compound, open reduction.....	150.00	0938	trimalleolar, simple, closed reduction.....	100.00
0811	skeletal pinning with external fixation.....	75.00	0940	compound, with anesthesia.....	100.00
0813	Ulna, shaft, simple, closed reduction.....	50.00	0941	simple or compound, open reduction.....	200.00
0814	shaft, simple, closed reduction with displacement and with anesthesia	50.00	0944	Tarsal (except astragalus and os calcis), one, simple, closed reduction.....	50.00
0815	compound	50.00	0945	one, compound, with anesthesia.....	50.00
0816	simple or compound, open reduction.....	100.00	0946	one, simple or compound, open reduction.....	100.00
0817	skeletal pinning with external fixation.....	50.00	0955	Astragalus, simple, closed reduction.....	75.00
0820	Radius and ulna, simple, closed reduction.....	75.00	0956	compound, with anesthesia.....	75.00
0821	simple, closed reduction with anesthesia.....	75.00	0957	simple or compound, open reduction.....	150.00
0823	simple or compound, open reduction.....	150.00	0961	Os Calcis, simple, closed reduction.....	50.00
0824	skeletal pinning with external fixation.....	75.00	0962	compound, with anesthesia.....	50.00
0827	Carpal bones, one, simple, closed reduction.....	50.00	0963	simple or compound, open reduction.....	100.00
0830	one, simple or compound, open reduction.....	100.00	0964	skeletal pinning with external fixation.....	50.00
0842	Metacarpal, one, simple, closed reduction.....	50.00	0967	Metatarsal, simple, closed reduction, one.....	40.00
0844	one, simple or compound, open reduction.....	100.00	0968	one, compound, with anesthesia.....	40.00
0848	skeletal pinning with external fixation.....	50.00	0970	one, simple or compound, open reduction.....	100.00
0852	Phalanx or phalanges, one finger, or thumb, simple, closed reduction	25.00	0980	Phalanx or phalanges, one toe, simple, closed reduction	25.00
0853	one finger, or thumb, compound.....	25.00	0982	one toe, simple or compound, open reduction.....	50.00
0854	simple or compound, open reduction.....	50.00			

Lower Extremity

0865	Femur, neck, simple, closed reduction, with fixation.....	125.00
0867	neck, simple or compound, open reduction.....	225.00
0868	multiple pinning, with or without external fixation	225.00
0872	intertrochanteric, simple, closed reduction with fixation	125.00
0874	simple, open reduction.....	225.00
0877	slipped epiphysis, closed reduction with fixation	125.00
0878	open reduction, acute.....	225.00
0879	reconstructive, late	225.00
0881	shaft, including supracondylar, simple, closed reduction	125.00
0883	simple or compound, open reduction.....	225.00
0884	skeletal pinning with external fixation.....	125.00
0885	Knee (distal end of femur, proximal end of tibia, proximal end of fibula) femur or tibia, condyle—closed reduction	125.00
0886	compound with general anesthesia.....	125.00
0887	simple or compound, open reduction.....	225.00
0889	two condyles (open)	225.00
0890	Femur, compound with general anesthesia.....	125.00
0891	simple or compound, open reduction.....	225.00
0895	Patella, simple	60.00
0896	compound with general anesthesia.....	60.00
0897	simple, open reduction.....	125.00
0901	Tibia, shaft, simple, closed reduction.....	100.00
0902	with anesthesia	100.00
0904	simple or compound, open reduction.....	200.00

Incision

ARTHROTOMY or capsulotomy with exploration, drainage or removal of loose body, e.g., osteochondritis or foreign body.

1001	Shoulder	75.00
1002	Elbow	75.00
1003	Wrist	75.00
1006	Other joints of upper extremity.....	75.00
1007	Hip	150.00
1008	Knee	100.00
1010	Ankle	100.00
1013	Other joints of lower extremity.....	75.00
1017	Finger, one	35.00
1026	Toe, one	35.00
1046	Arthrocentesis: puncture for aspiration of joint, or injection of medication, initial.....	10.00
1047	subsequent	10.00

Excision

ARTHRECTOMY—Excision of joint (see Arthrodesis).

1061	Punch biopsy of synovial membrane.....	15.00
1065	Temporomandibular joint, unilateral.....	250.00
1074	Excision of intervertebral disk.....	250.00
1075	with spinal fusion.....	250.00
1077	Excision of neural arch and nerve exploration for spondylolisthesis	250.00
1082	Meniscectomy: excision of semilunar cartilage of knee joint	125.00
1085	Meniscectomy temporomandibular joint.....	200.00
1093	Synovectomy, elbow	125.00
1101	hip, complete	250.00
1102	knee	150.00
1103	ankle	150.00

Introduction

- 1131 Arthrography: injection of air or radiopaque material into joint for roentgen examination (x-ray charges not included) 10.00

Repair

ARTHROPLASTY—Plastic or reconstructive operation on joint, any type.

- 1141 Shoulder 175.00
1142 Elbow 175.00
1143 Wrist 175.00
1144 Finger, one joint.....100.00
1150 Hip 300.00
1151 Knee 200.00
1152 Ankle 125.00
1153 Toe, one joint.....100.00
1162 Metatarsophalangeal joint; bunion operation.....60.00

ARTHRODESIS—Fusion of joint, with or without tendon transplant.

- 1166 Shoulder 150.00
1167 Elbow 125.00
1168 Wrist 150.00
1170 Finger, thumb, one joint.....75.00
1175 Hip 250.00
1176 Knee 200.00
1177 Ankle 150.00
1178 Hammer toe, operation, one toe.....40.00
1181 Hallux rigidus, repair of.....40.00
1183 Tarsal, joints, one or more.....50.00
1184 Other joints, lower extremity.....50.00
1185 Foot, triple arthrodesis, unilateral.....200.00
1187 Foot, with tendon transplantation.....200.00
1190 Stabilization of joints by bone block.....S/R

Suture

- 1201 Capsulorrhaphy: suture or repair of joint capsule (independent procedure) for recurrent dislocation, shoulder 200.00
1202 patella 150.00
1211 Suture of torn, ruptured or severed collateral ligaments, knee 150.00
1212 Suture of torn, ruptured or severed cruciate, knee.....200.00
1213 Suture of torn, ruptured or severed collateral and cruciate, knee 200.00
1215 Reconstruction, both collateral or cruciate ligaments, knee 200.00
1216 Reconstruction, both collateral ligaments, ankle.....150.00
1217 Reconstruction both metacarpophalangeal or interphalangeal 150.00

Manipulation

Manipulation of joint under anesthesia, including application of cast or traction. (Independent procedure) (dislocations excluded.)

- 1221 Shoulder 35.00
1222 Elbow 35.00
1223 Wrist 35.00
1224 Digits, one or more, under anesthesia, where no other surgical procedure is performed.....25.00
1226 Hip 35.00
1227 Knee 35.00
1228 Ankle 35.00
1232 Spine S/R
1233 Manipulation of shoulder for fibrous ankylosis, under anesthesia 35.00
1241 Turnbuckle jacket, body only, for scoliosis.....50.00

- 1242 Turnbuckle spica jacket for scoliosis.....75.00
1244 Club foot and application of cast, unilateral.....15.00
1245 application of subsequent casts, unilateral.....15.00
1246 application of cast, bilateral, initial.....30.00
1247 application of subsequent casts, bilateral.....30.00

Dislocations

- 1251 Temporomandibular, simple, closed reduction.....15.00
1256 Vertebra, cervical, simple, closed reduction with anesthesia 150.00
1258 cervical, simple or compound, with operation.....300.00
1262 dorsal, simple, closed reduction with anesthesia 125.00
1264 dorsal, simple or compound, with operation.....250.00
1267 lumbar, simple, closed reduction with anesthesia 125.00
1270 lumbar, simple or compound, with operation.....250.00
1273 Clavicle, sternoclavicular, simple, closed reduction.....35.00
1274 compound, with anesthesia.....35.00
1275 simple or compound, open reduction.....125.00
1278 acromioclavicular, simple, closed reduction.....50.00
1281 simple or compound, open reduction.....125.00
1284 Shoulder (humerus), simple, closed reduction.....40.00
1286 simple or compound, open reduction.....200.00
1290 Elbow, simple, closed reduction.....50.00
1291 compound, with anesthesia.....50.00
1292 simple or compound, open reduction.....100.00
1295 Wrist, carpal, one bone, simple, closed reduction.....35.00
1296 compound, with anesthesia.....35.00
1297 simple or compound, open reduction.....125.00
1298 more than one bone, simple, closed reduction.....70.00
1300 compound, with anesthesia.....70.00
1301 simple or compound, open reduction.....125.00
1304 Metacarpal, one bone, simple, closed reduction.....25.00
1305 one bone, compound, with anesthesia.....25.00
1306 simple or compound, open reduction.....100.00
1315 Finger, one, one or more joints, simple, closed reduction 15.00
1316 compound 15.00
1317 simple or compound, open reduction.....50.00
1326 Thumb, simple, closed reduction.....15.00
1327 compound, general anesthesia.....15.00
1328 simple or compound, open reduction.....75.00
1332 Hip (femur), simple, closed reduction.....75.00
1334 simple or compound, open reduction.....200.00
1338 congenital, closed reduction.....75.00
1340 dislocation complicated S/R
1344 Knee (tibia), simple, closed reduction.....75.00
1345 compound, with general anesthesia.....75.00
1346 simple or compound, open reduction.....150.00
1350 Patella, simple, closed reduction.....25.00
1351 compound, with anesthesia.....25.00
1352 simple or compound, open reduction.....150.00
1355 Ankle, simple, closed reduction.....75.00
1356 compound, with anesthesia.....75.00
1357 simple or compound, open reduction.....150.00
1361 Tarsal, simple, closed reduction.....50.00
1362 compound, with anesthesia.....50.00
1363 simple or compound, open reduction.....100.00
1371 Astragalo-tarsal, simple, closed reduction.....75.00
1372 compound, with anesthesia.....75.00
1373 simple or compound, open reduction.....150.00
1376 Metatarsal, one bone, simple, closed reduction.....30.00
1377 compound, general anesthesia.....30.00
1378 simple or compound, open reduction.....100.00
1385 Toe, one, simple, closed reduction.....10.00
1386 compound, with anesthesia.....10.00
1387 simple or compound, open reduction.....50.00

91	more than one, one or more joints, simple, closed reduction	25.00
92	compound	25.00

BURSAE

Incision

02	Drainage of infected bursa.....	
	in hospital with general anesthesia.....	15.00
06	Removal of subdeltoid calcareous deposits.....	50.00
10	Removal of subtrochanteric calcareous deposits.....	50.00
13	Puncture for aspiration of bursae, initial.....	10.00
18	subsequent	10.00 (max. 30.00)
24	Needling of bursa.....	10.00
25	subsequent	10.00 (max. 30.00)
27	with irrigation of bursa.....	10.00
28	subsequent with irrigation of bursa.....	10.00

Excision

130	Radical excision of bursae, forearm, viz., tenosynovitis fungosa, Tbc., and other granulomas.....	150.00
131	Excision of bursa, olecranon.....	50.00
133	prepatellar	50.00
135	subacromial	50.00
136	ischial	125.00

MUSCLES

Incision

150	Removal of foreign body in muscle, general anesthesia	S/R
154	Division of scalenus anticus, without resection of cervical rib	75.00
156	with resection of cervical rib.....	125.00
158	Division of sternomastoid for torticollis, open operation	75.00

Repair

1487	Repair of diaphragmatic hernia.....	250.00
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Suture

1495	Suture of ruptured diaphragm.....	250.00
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TENDONS, TENDON SHEATHS AND FASCIA

Incision

1511	Drainage of tendon sheath, infection for acute tenosynovitis, one digit.....	50.00
1512	one digit, see extremities-incision.....	50.00
1514	Drainage of tendon sheath, infection for tenosynovitis, single palm and/or wrist, ulnar or radial bursa infection, in hospital	S/R
1517	Injection of hydrocortone or other medication, tendon sheath, hand	10.00
1519	Incision of fibrous sheath of tendon for stenosing tenosynovitis, to include freeing of tendons or removal of foreign body, in hospital.....	40.00
1531	Division of iliotibial band, open operation.....	75.00
1534	Stripping of ilium (Soutter operation).....	75.00
1535	Tenotomy, corrective, single digit, subcutaneous.....	35.00
1536	corrective, multiple	75.00
1539	hip abductors, subcutaneous.....	50.00
1541	open	75.00

Excision

1552	Excision of lesion of tendon or fibrous sheath, including ganglion, digits only.....	65.00
1553	in other locations.....	65.00

1555	Radical excision of bursae, forearm, viz., tenosynovitis fungosa, Tbc., and other granulomas (see 1430).	
1562	Excision of Baker's cyst (synovial cyst of popliteal space)	125.00
1570	Fasciotomy, single, palm or sole, subcutaneous, blind	35.00
1573	for Dupuytren's contracture, partial.....	100.00
1574	including finger extensions and vertical bands, radical	200.00

Repair

1580	Repair or suture extensor tendon, single, hand or foot, distal to wrist or ankle.....	50.00
1582	single, forearm or leg.....	50.00
1583	Repair or suture flexor tendon, single, unless otherwise listed	50.00
1585	Transfer, or transplant, or free graft of tendon, single, distal to elbow, distal to knee.....	90.00
1586	single, elbow to shoulder, knee to hip.....	90.00
1587	Tenolysis, single	40.00
1589	Lengthening or shortening tendon.....	75.00
1592	Retrieve or re-route tendon through separate incision, add 50% of appropriate fee.	
1612	Free fascial graft for reconstruction tendon pulley or repair bowstring tendon, single (independent procedure)	50.00
1613	for reconstruction tendon pulley or repair bowstring tendon to form gliding surface for tendons.....	75.00
1616	Abdominal fascial transplants, bilateral.....	225.00
1617	Free fascial graft to face.....	S/R
1632	Patellar advancement	125.00
1633	Rupture quadriceps insertion.....	125.00
1640	Rupture biceps tendon from insertion elbow.....	125.00
1641	Flexor plasty elbow.....	125.00
1654	Repair ruptured supraspinatus tendon or musculotendinous cuff shoulder.....	150.00
1655	Suture of complete shoulder cuff avulsion.....	200.00

EXTREMITIES

Incision

1682	Drainage of felon in hospital with general anesthesia	35.00
1686	Drainage of single, infected, space of hand (lumbrical, hypothenar, thenar, middle palmar, etc.) with or without tendon sheath involvement, in hospital.....	35.00
1692	Drainage of multiple, infected spaces of hand (with or without tendon sheath involvement) in hospital.....	60.00

Amputation

Upper Extremity

1701	Interthoracoscaphar	250.00
1703	Disarticulation of shoulder.....	250.00
1705	Arm through humerus.....	125.00
1708	Forearm, through radius and ulna.....	125.00
1712	Cineplasty, complete procedure.....	200.00
1718	Disarticulation of wrist.....	125.00
1722	Hand through metacarpal bones.....	100.00
1725	Metacarpal, with finger or thumb, one, with split or Wolff graft, or skin plastic and/or tenodesis with definitive resection palmar digital nerve.....	100.00
1737	Finger, any joint, or phalanx, one, with split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection volar digital nerves.....	75.00

Lower Extremity

1745	Interpelviabdominal	S/R
1748	Disarticulation of hip.....	250.00
1750	Disarticulation of knee.....	150.00
1752	Thigh through femur, including supracondylar.....	200.00

1760	Guillotine, thigh	150.00
1763	with subsequent revision or reamputation (same surgeon)	225.00
1767	Leg, through tibia and fibula.....	150.00
1771	Guillotine, leg	150.00
1774	with subsequent revision or reamputation (same surgeon)	225.00
1778	Ankle (Syme, Pirogoff), with skin plastic, and resection nerves	150.00
1782	Foot, transmetatarsal, each foot.....	100.00
1785	midtarsal	100.00
1788	Metatarsal with toe, split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection digital nerves	100.00
1802	Toe, any joint or phalanx, one.....	25.00
1803	Toe, more than one, split or Wolff graft, or skin plastic and/or tenodesis, with definitive resection digital nerves	100.00

Repair

1811	Freeing of web fingers, with flaps.....	90.00
1815	with graft	150.00

PLASTER CASTS (Independent Procedure Only)

1851	Molded plaster to forearm.....	10.00
1854	elbow to fingers.....	10.00
1856	hand and wrist.....	10.00
1860	shoulder to hand.....	10.00
1862	shoulder spica	25.00
1865	ankle (foot to mid leg).....	10.00
1867	knee (foot to thigh).....	10.00
1871	Ambulatory leg cast.....	10.00
1875	Molded plaster to leg.....	10.00
1878	Spica, unilateral (hip to foot).....	25.00
1882	bilateral	35.00
1885	Body, shoulder to hips.....	35.00
1886	including head	50.00
1891	Unna boot	10.00

Respiratory System

NOSE

Incision

1901	Drainage of nasal abscess.....	20.00
1905	Drainage of septal abscess.....	20.00

Excision

1911	Biopsy, soft tissue, nose.....	10.00
1915	Excision of nasal polyp.....	15.00
1917	Excision nasal polyps, multiple, unilateral or bilateral, one or more stages, hospital, with anesthesia.....	35.00
1922	Excision of nasopharyngeal fibroma.....	100.00
1928	Septectomy: submucous resection.....	100.00
1935	Submucous resection of turbinate, complete or partial, unilateral or bilateral (independent procedure).....	35.00

Endoscopy

1941	Rhinoscopy with removal of foreign body in nose.....	10.00
1942	with general anesthesia.....	25.00
1943	by way of lateral rhinoplasty.....	S/R

Destruction

1965	Cauterization of turbinates, unilateral or bilateral (independent procedure).....	15.00
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Manipulation

1970	Reduction of fractured nasal bones (see 0686 to 0688)	
1971	Control of primary nasal hemorrhage, with cauterization of septum.....	10.00
1975	with nasal pack in hospital.....	10.00
1978	by ligation of ethmoid artery.....	50.00

ACCESSORY SINUSES

Incision

1981	Antrum puncture, unilateral, initial.....	15.00
	subsequent	10.00
1985	Maxillary sinusotomy, simple, antrum window operation, unilateral	75.00
1986	bilateral	100.00
1988	Radical (Caldwell-Luc), unilateral.....	150.00
1991	Sphenoid sinusotomy	100.00
1992	Frontal sinusotomy, external, simple (trephine operation)	100.00
1993	radical	150.00
1994	Combined external frontal, ethmoid and sphenoid sinusotomy, unilateral	200.00

Excision

2006	Ethmoidectomy, intranasal, unilateral.....	75.00
2013	external, unilateral	175.00
2016	bilateral	250.00

Suture

2031	Closure of dental fistula of maxillary sinus with flap or radical antrotomy	150.00
2032	Closure oro-nasal fistula (local mucoperiosteal pedicle flaps)	100.00

LARYNX

Incision

2041	Laryngofissure with removal of tumor.....	150.00
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Excision

2051	Laryngectomy, without neck dissection.....	250.00
2054	with neck dissection.....	S/F
2055	Hemilaryngectomy	200.00
2057	Epiglottidectomy, external approach.....	150.00
2058	end-oral approach	50.00

Introduction

2061	Injection of radiopaque substance into larynx for bronchography, indirect method.....	15.00
2063	direct with bronchoscope.....	40.00

Endoscopy

2071	Laryngoscopy, direct, diagnostic (independent procedure)	15.00
2074	with biopsy	35.00
2077	operative, including removal of foreign body....	50.00
2081	including removal of papilloma or other tumor.....	60.00
2087	Lynch suspension, in hospital.....	35.00

TRACHEA AND BRONCHI

Incision

2101	Tracheotomy (independent procedure).....	90.00
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Endoscopy

2111	Bronchoscopy, diagnostic	40.00
2113	with biopsy	40.00
2117	with removal of foreign body.....	100.00

2120	with excision of tumor.....	60.00
2121	with aspiration of bronchus.....	40.00
2122	with drainage of lung abscess or cavity, initial.....	40.00
2123	with lipiodol injection.....	40.00
2124	subsequent	40.00
2126	Bronchospirrometry and catheterization of bronchi (independent procedure)	40.00
2127	Tracheal aspiration (independent procedure) under direct vision	40.00
2128	indirect	5.00

Repair

2131	Tracheoplasty: plastic operation on trachea, cervical	200.00
2132	intrathoracic	250.00
2133	Bronchoplasty (graft repair).....	275.00
2134	(excise stenosis and anastomosis).....	275.00
2135	with lobectomy and anastomosis.....	300.00

Suture

2141	Tracheorrhaphy: suture of external tracheal wound or injury, depending on structure and extent of injury (cervical)	100.00
2142	(intrathoracic)	250.00
2144	Closure of tracheostomy or tracheal fistula.....	75.00
2147	Closure of tracheo-esophageal fistula.....	300.00

LUNGS AND PLEURA

Incision

2151	Thoracotomy, exploratory, including control of hemorrhage and/or biopsy and cardiac massage.....	150.00
2154	with open drainage of empyema cavity by rib resection (independent procedure).....	100.00
2157	with closed drainage of empyema cavity; tube drainage with negative pressure (independent procedure)	50.00
2160	with removal of intrapleural foreign body or fibrin body	175.00
2163	with open intrapleural pneumonolysis.....	175.00
2166	Pneumonotomy, exploratory	150.00
2170	with open drainage of pulmonary abscess or cyst	175.00
2173	with removal of foreign body from lung.....	175.00
2176	Cruciate incision of thickened scar deposited on visceral pleura	175.00
2177	Total pulmonary decortication.....	250.00
2180	Pneumonocentesis: puncture of lung for aspiration biopsy	25.00
2183	Thoracentesis: puncture of pleural cavity for aspiration, initial	10.00
2186	subsequent	10.00 (max. 100.00)

Excision

2191	Total pneumonectomy	300.00
2193	Total or subtotal lobectomy.....	300.00
2194	Wedge resection	150.00
2196	Pleurectomy, any type (independent procedure).....	250.00

Endoscopy

2201	Thoracoscopy, exploratory (independent procedure)	50.00
2204	with biopsy	50.00
2207	Closed intrapleural pneumonolysis.....	125.00

Surgical Collapse Therapy

THORACOPLASTY—Extrapleural resection of ribs, any type.		
2211	first stage	175.00

2212	second stage	100.00
2213	third stage	100.00
2217	Extrapleural pneumonolysis, including associated filling or packing procedures.....	175.00
2221	Pneumothorax: intrapleural injection of air, initial.....	15.00
2222	subsequent	5.00 (max. 100.00)

Cardiovascular System

HEART AND PERICARDIUM

Incision

2301	Cardiotomy with exploration or removal of foreign body	300.00
2305	Pericardiotomy with exploration, drainage or removal of foreign body	250.00
2310	Pericardiocentesis: puncture of pericardial space for aspiration	15.00
2311	subsequent	15.00
2315	Valvulotomy or commissurotomy.....	300.00
2316	Operation for regurgitation.....	300.00
2317	Operation for coronary disease (poudrage).....	250.00

Excision

2321	Pericardiectomy	300.00
2325	Valvulectomy	300.00
2326	Excision of auricular appendage.....	250.00

Introduction

2331	Catherization of the heart (independent procedure) S/R	25.00
2332	Injection for angiocardiograms.....	25.00
2333	Retrograde aortography—cut down and pass catheter	75.00

Destruction

2341	Cardiolysis	300.00
2345	Pericardiolysis	300.00

Suture

2351	Cardiorrhaphy: suture of heart wound or injury.....	300.00
2352	suture I-A septal defect.....	300.00
2355	Pericardiorrhaphy: suture of pericardial wound or injury	250.00

ARTERIES AND VEINS

Incision

ARTERIOTOMY—With removal of embolus:

2373	Trunk	225.00
2376	Neck	125.00
2380	Extremity	125.00

PHLEBOTOMY—With removal of thrombus:

2397	Trunk	150.00
2401	Neck	90.00
2404	Extremity	90.00

Excision

2424	Excision of arch of aorta and insertion of graft.....	S/R
2425	Excision of arteriovenous aneurysm.....	S/R
2426	Excision of coarctation of aorta.....	300.00
2427	Repair of thoracic or abdominal aorta.....	300.00
2428	Popliteal aneurysm	135.00

Introduction

2431	Filipuncture: wiring of aneurysm extremity.....	150.00
2432	wiring of aneurysm aortic.....	250.00
2434	Arteriography (exclusive of x-ray allowance).....	25.00
2435	(exclusive of x-ray allowance) lumbar.....	25.00

2440	Venography (exclusive of x-ray allowance).....	20.00
2445	Blood transfusion, indirect method.....	10.00
2446	replacement type, Rh factor, one or more, max.	200.00
2448	direct method	25.00
2454	Injection of sclerosing solution into vein of leg, initial, unilateral	5.00
2461	subsequent, unilateral	5.00

Repair

2472	Repair of aortic arch anomalies.....	300.00
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ARTERIAL ANASTOMOSIS:

2475	Aortic anastomosis	300.00
2478	Pulmonary aortic anastomosis (Potts).....	300.00
2482	Pulmonary subclavian anastomosis (Blalock).....	300.00
2485	Pulmonary innominate anastomosis (Blalock).....	300.00

VENOUS ANASTOMOSIS:

2490	Portocaval anastomosis	300.00
2496	Splenorenal anastomosis	300.00
2501	Plastic operation for repair of arterio-venous aneu- rysm	S/R

Suture

2511	Arteriorrhaphy: suture of wound or injury of artery	175.00
2515	Phleborrhaphy: suture of wound or injury of vein.....	125.00
2520	Ligation of ductus arteriosus and division.....	300.00
2522	Ligation of carotid artery.....	50.00
2525	Ligation and division of inferior vena cava.....	200.00
2526	Ligation of femoral vein.....	90.00
2530	Ligation and division of common iliac vein.....	175.00
2558	Ligation and division of long saphenous vein at sapheno- femoral junction with or without retrograde injection, or distal interruptions.....	30.00
2561	Ligation and division and complete stripping of long or short saphenous veins.....	50.00
2563	of long and short saphenous veins.....	100.00
2576	Ligation and division of short saphenous vein at sapheno- popliteal junction	30.00
2581	of minor varicose vein of leg, initial.....	15.00
2585	subsequent	15.00

Hemic and Lymphatic Systems

SPLEEN

Excision

2601	Splenectomy	200.00
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LYMPH NODES AND LYMPHATIC CHANNELS

Incision

2631	Drainage of lymph node abscess or lymphadenitis.....	25.00
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Excision

2641	Biopsy of lymph node.....	15.00
2642	of lymph node (anterior scalene).....	15.00
2644	Excision of lymph node.....	30.00

RADICAL LYMPHADENECTOMY — Radical resection of lymph nodes.

2652	Upper neck	75.00
2658	Axilla	125.00
2665	Cervical (complete), unilateral.....	250.00
2672	Groin	150.00

Mediastinum

Incision

2680	Mediastinotomy with exploration or drainage.....	175
2683	Foreign body removal, cervical.....	175

Excision

2691	Excision of mediastinal cyst.....	300
2693	Excision of mediastinal tumor.....	300
2696	Repair thoracic duct (suture).....	275
2697	Plastic anastomosis thoracic duct.....	300

Digestive System

MOUTH

Incision

2701	Drainage of sublingual abscess.....	25
2705	Drainage of Ludwig's angina.....	90

LIPS

Excision

2743	V-excision of lesion of lips up to one-half lip.....	100.
2744	Resection of more than one-half lip with plastic closure (see 0260 to 0312).	
2746	without plastic closure.....	100.
2747	Secondary plastic closure (see 0260 to 0312).	

Repair

2751	Cheiloplasty: plastic or reconstruction operation on lip (see 0260 to 0312).	
2754	Plastic repair of harelip, primary, unilateral.....	125.
2758	primary, bilateral, one stage.....	150.
2759	bilateral, two stages, per stage.....	100.
2761	secondary, local revision, unilateral or bilateral (see 0260 to 0312).	
2762	Plastic repair of unilateral harelip by re-creation defect and reclosure.....	125.
2765	Plastic repair of bilateral harelip by re-creation of defect and reclosure—per major stage.....	150.

TONGUE

Incision (Glossotomy)

2771	Drainage of lingual abscess.....	15.0
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Excision (Glossectomy)

2781	Biopsy of tongue (see 0260 to 0262).	
2785	Partial glossectomy or hemiglossectomy (electrocoagulation)	125.0
2787	Complete or total glossectomy.....	175.0

Repair

2791	Glossoplasty: plastic operation on tongue (see 0260 to 0312).	
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Suture

2801	Glossorrhaphy: suture of tongue wound or injury (see 0260 to 0262).	
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TEETH AND GUMS

Incision

2815	Drainage of alveolar abscess, acute with cellulitis— oral	15.0
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PALATE AND UVULA

Incision

2871 Incision and drainage of palate (abscess).....15.00

Excision

2881 Biopsy of palate (see 0260).
2883 Excision of local lesion of palate (see 0260 to 0262).
2884 with graft or flap closure (see 0275 to 0319).
2885 Resection of palate or wide excision of lesion of palate 75.00
2886 Resection of palate with reconstruction (see 0275 to 0319).
2887 Uvulectomy: excision of uvula.....15.00

Repair

2890 Palatoplasty: plastic operation for partial cleft palate 175.00
2892 plastic operation for complete cleft palate, including alveolar ridge 250.00
2894 secondary minor revision (see 0260 to 0276).
2895 major revision 175.00
2897 secondary lengthening procedure.....100.00
2898 attachment pharyngeal flap.....100.00

Suture

2901 Suture palate wound or injury (see 0265 to 0267).

SALIVARY GLANDS AND DUCTS

Incision

2911 Drainage of parotid abscess.....40.00
2915 Sialolithotomy: removal of salivary calculus, local anesthesia 40.00
2916 Sialolithotomy: extra-orally 75.00

Excision

2921 Biopsy of salivary gland.....15.00
2927 Excision of parotid tumor.....150.00
2930 of submaxillary tumor.....100.00
2931 of submaxillary gland.....100.00
2934 of parotid gland with preservation of facial nerve 225.00
2937 with sacrifice of facial nerve.....200.00

Repair

2941 Plastic repair of salivary duct: sialodochoplasty.....75.00

Suture

2951 Closure of salivary fistula.....75.00

Manipulation

2961 Dilation of salivary duct; pyalectasis.....10.00

PHARYNX, ADENOIDS, AND TONSILS

Incision

2971 Drainage of retropharyngeal abscess, internal approach 20.00
2974 external approach S/R
2977 Drainage of peritonsillar abscess.....20.00
2983 Biopsy of pharynx, local anesthesia or general anesthesia, in hospital 20.00
2984 Excision of pharyngoesophageal diverticulum, first stage 100.00
2986 second stage 100.00
2987 single stage 200.00

2989 Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues.....75.00
2990 extending beneath subcutaneous tissues.....125.00
2992 Tonsillectomy, with or without adenoidectomy, any age 60.00
2996 Adenoidectomy (independent procedure).....30.00
3000 Excision of tonsil tag, unilateral, hospital.....15.00
3004 Excision of lingual tonsil (independent procedure).....20.00

Repair

3011 Pharyngoplasty: plastic or reconstructive operation on pharynx (see 0260 to 0319).

Suture

3021 Suture of external wound or injury of pharynx.....60.00

ESOPHAGUS

Incision

3031 Esophagotomy 200.00
3032 for removal of foreign body.....250.00
3033 intrathoracic 300.00

Excision

3043 Esophagectomy: resection of esophagus, transpleural or extrapleural 300.00
3044 Local excision, end to end anastomosis.....300.00
3046 Esophagogastrectomy combined thoracoabdominal....S/R

Endoscopy

3051 Esophagoscopy, diagnostic 40.00
3053 with insertion of radioactive substance.....40.00
3055 with biopsy 40.00
3057 with foreign body removal.....100.00
3061 with dilation, direct.....40.00
3063 subsequent 40.00

Repair

3071 Esophagoplasty: plastic repair or reconstruction of esophagus 300.00
3072 Esophagogastrostomy (cardioplasty) 300.00
3073 Esophagoduodenostomy 300.00
3074 Esophagojejunostomy 300.00
3075 Esophagostomy; fistulization of esophagus, external 200.00
3076 Esophagomyotomy (Heller) 200.00

Suture

3081 Suture of esophageal wound, injury or rupture, cervical approach 175.00
3083 intrathoracic 300.00
3086 Closure of esophagostomy or other external esophageal fistula, cervical.....175.00
3087 thoracic 300.00

Manipulation

3091 Dilation of esophagus by sound, bougie or bag, initial, direct (see 3061).
3092 initial, indirect 25.00
3095 subsequent 15.00 (max. 150.00)

STOMACH

Incision

3101 Gastrotomy with exploration or foreign body removal 150.00
3105 Pyloromyotomy: cutting of pyloric muscle (Fredet-Ramstedt operation) 150.00

Excision

3111 Biopsy of stomach, with laparotomy.....	135.00
3112 Local excision of stomach ulcer or benign neoplasm	150.00
3114 Total gastrectomy	300.00
3115 Subtotal gastrectomy	300.00

Endoscopy (independent procedure)

3121 Gastroscopy, diagnostic	40.00
3123 with biopsy	40.00
3131 Pyloroplasty	175.00
3133 Gastroduodenostomy	175.00
3135 Gastrojejunostomy	175.00
3136 with partial vagectomy; vagotomy.....	225.00
3137 Gastrostomy for feeding.....	100.00

Suture

3141 Gastrorrhaphy: suture of perforated gastric ulcer, wound or injury.....	150.00
3144 Closure or taking down of gastroduodenal anastomosis (gastroduodenostomy)	250.00
3146 Closure or taking down of gastrojejunal anastomosis (gastrojejunostomy)	250.00
3153 Closure of gastrostomy.....	125.00

INTESTINES (Except Rectum)

Incision

3161 Enterotomy with exploration or foreign body removal, small bowel	150.00
3162 large bowel	150.00
3166 Exteriorization of intestine, preliminary to resection; first stage Mikulicz, resection of intestine.....	150.00

Excision

3171 Excision of one or more intestinal lesions not requiring anastomosis, exteriorization or fistulization.....	175.00
3174 Enterectomy: resection of small intestine with anastomosis	225.00
3178 Colectomy: resection of large intestine, all or part, one or two stages, including colostomy and closure, if necessary	300.00
3179 Colectomy, partial, with anastomosis and with or without proximal colostomy.....	300.00
3180 total, with or without ileostomy or anastomosis	300.00
3181 total, with total proctectomy and ileostomy.....	S/R
3191 Enteroenterostomy: anastomosis of intestines.....	175.00

ENTEROSTOMY—External fistulization of intestines.

3193 small (ileostomy or jejunostomy).....	150.00
3195 large (colostomy)	135.00
3197 small or large, for ulcerative colitis.....	150.00
3200 Reduction of volvulus, intussusception, internal hernia (by laparotomy)	135.00
3204 Revision of colostomy, hospital.....	50.00
3205 Cecopexy: fixation of colon to abdominal wall.....	125.00

Destruction

3211 Enterolysis: freeing of intestinal adhesion.....	125.00
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Suture

3221 Suture of intestine (enterorrhaphy), large or small, for perforated ulcer, wound, injury or rupture.....	150.00
3222 Suture of intestine with colostomy.....	150.00
3225 Closure of enterostomy, large or small intestine.....	125.00
3227 Closure of fecal fistula.....	S/R

MECKEL'S DIVERTICULUM AND THE MESENTERY

Excision

3231 Excision of Meckel's diverticulum (diverticulectomy)	125.0
3235 Excision of lesion of mesentery.....	125.0

Suture

3241 Suture of mesentery.....	125.0
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APPENDIX

Incision

3251 Incision and drainage of appendical abscess.....	100.0
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Excision

3261 Appendectomy	125.0
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RECTUM

Incision

3283 Incision and drainage perirectal abscess.....	25.00
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Excision

3291 Complete proctectomy, combined abdominoperineal, one or two stages.....	300.00
3292 Complete proctectomy for congenital megacolon.....	300.00
3294 Excision of rectal procidentia.....	125.00
3296 Division of stricture in rectum.....	125.00
3297 Valvotomy	80.00
3298 Perineal excision of recurrent malignant tumor.....	125.00

Endoscopy (independent procedure)

3311 Proctosigmoidoscopy, diagnostic, initial.....	10.00
3312 subsequent	5.00
3313 with biopsy, initial.....	10.00
3314 subsequent	10.00
3315 with removal of papillomas or polyps, initial.....	45.00
3316 subsequent	15.00
3317 with removal of multiple papillomas or polyps	45.00
3319 Sigmoidoscopic control of hemorrhage.....	10.00

Repair

3321 Proctoplasty, perineal, for stricture or prolapse.....	90.00
3322 Perirectal injection of sclerosing solution for prolapse	10.00
3325 Proctopexy, abdominal, for prolapse.....	175.00

Suture

3331 Closure of rectovesical fistula.....	135.00
3333 Closure of rectourethral fistula.....	200.00
3335 Closure of rectovaginal fistula.....	125.00

Manipulation (independent procedure)

3341 Reduction of prolapse of rectum.....	25.00
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ANUS

Incision

3353 Fistulotomy or fistulectomy, simple.....	80.00
3354 complicated or multiple.....	80.00
3355 Second stage, fistulectomy.....	50.00
3358 Incision and drainage of ischiorectal abscess with fistulotomy or fistulectomy.....	80.00
3364 Sphincterotomy, anal: division of anal sphincter.....	30.00

Excision

3371	Fissurectomy, with or without sphincterotomy.....	50.00
3373	Cryptectomy, single or multiple (independent procedure)	35.00
3374	Papillectomy, single or multiple (independent procedure)	45.00
3377	Hemorrhoidectomy, external only.....	15.00
3380	internal and external.....	80.00
3382	Fistulotomy or fistulectomy and hemorrhoidectomy.....	80.00
3386	Fissurectomy and hemorrhoidectomy.....	80.00
3392	Enucleation of external thrombotic hemorrhoid.....	15.00
3395	Excision of external hemorrhoidal tabs.....	15.00

Endoscopy (independent procedure)

3411	Anoscopy, diagnostic	5.00
3413	with biopsy	10.00
3415	with removal of foreign body.....	15.00
3416	subsequent	5.00
3417	Control of hemorrhage—endoscopic.....	10.00

Repair

3420	Anoplasty: plastic operation for imperforate anus or stricture	S/R
3421	Anoplasty, infant	90.00
3423	adult	90.00
3425	Sphincteroplasty, anal: plastic operation for incontinence	175.00
3426	Thiersch procedure for incontinence and/or prolapse	100.00
3427	Construction of anus, for congenital absence.....	100.00
3428	combined abdominoperineal approach.....	250.00

Destruction

3433	Condyloma, single or multiple, internal.....	45.00
3434	subsequent	10.00

Manipulation

3441	Dilation of anal sphincter under anesthesia.....	15.00
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LIVER

Incision

3456	Aspiration biopsy of liver.....	15.00
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Excision

3464	Hepatectomy, partial; resection of liver.....	250.00
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Repair

3471	Marsupialization of cyst or abscess of liver.....	200.00
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Suture

3481	Hepatorrhaphy: suture of liver wound or injury....	175.00
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BILIARY TRACT

Incision

3491	Hepaticotomy, with exploration, drainage (hepaticostomy) or removal of calculus.....	250.00
3495	Choledochotomy or choledochostomy with exploration, drainage or removal of calculus, with or without cholecystectomy	200.00
3500	Duodenocholedochotomy: transduodenal choledocholithotomy	200.00
3504	Cholecystotomy or cholecystostomy with exploration, drainage or removal of calculus.....	150.00

Excision

3515	Cholecystectomy	200.00
3517	with exploration of common duct.....	200.00

PANCREAS

Incision

3541	Pancreatotomy for drainage of pancreatitis.....	150.00
3544	Removal of calculus.....	175.00

Repair

3565	Marsupialization of cyst of pancreas.....	175.00
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ABDOMEN, PERITONEUM AND OMENTUM

Incision

3571	Exploratory laparotomy: exploratory celiotomy....	100.00
3573	Drainage of peritoneal abscess or localized peritonitis exclusive of appendical abscess.....	100.00
3575	Subdiaphragmatic or subphrenic abscess, one or two stages	150.00
3578	Retroperitoneal abscess	100.00
3588	Peritoneocentesis: abdominal paracentesis, initial.....	10.00
3590	subsequent	10.00 (max. 100.00)

Introduction

3611	Pneumoperitoneum: intraperitoneal injection of air, initial	10.00
3612	subsequent	10.00 (max. 100.00)

HERNIOPLASTY: HERNIORRHAPHY:

HERNIOTOMY

3631	Inguinal, unilateral	125.00
3632	with appendectomy	125.00
3633	with orchiectomy	125.00
3634	with excision of hydrocele.....	125.00
3635	recurrent	150.00
3638	Inguinal, bilateral	175.00
3640	with appendectomy	175.00
3641	with orchiectomy	175.00
3642	with excision of hydrocele.....	175.00
3643	recurrent	200.00
3646	Femoral, unilateral	125.00
3647	with appendectomy	125.00
3651	recurrent	150.00
3654	Femoral, bilateral	175.00
3658	recurrent	200.00
3661	Ventral, incisional	125.00
3662	recurrent	150.00
3663	Epigastric	125.00
3664	recurrent	150.00
3665	Umbilical	125.00
3667	Omphalocele	S/R
3709	Diaphragmatic (see Musculoskeletal System 1487).	

Suture

3734	Secondary suture of abdominal wall for evisceration or disruption	75.00
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Urinary System

KIDNEY

Incision

3802	Drainage of perirenal abscess (independent procedure)	125.00
3806	Exploration with or without nephrotomy.....	200.00
3808	Nephrostomy with drainage.....	200.00
3811	Nephrolithotomy, removal of calculus.....	210.00
3813	Division or transection of aberrant renal vessels (independent procedure)	175.00

3815	Pyelotomy with exploration.....	175.00
3816	Pyclostomy with drainage.....	175.00
3817	Pycloolithotomy	175.00

Excision

3820	Renal biopsy (by trochar or needle).....	15.00
3821	Nephrectomy	250.00
3822	plus total ureterectomy.....	275.00
3824	partial	250.00
3827	Excision of cyst of kidney.....	175.00
3829	Aspiration or injections of renal cyst or renal pelvis.....	45.00

Introduction

3830	Perirenal insufflation, unilateral or bilateral.....	45.00
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Repair

3831	Pycloplasty: plastic operation on renal pelvis, with or without plastic operation on ureter.....	250.00
3835	Nephropexy: fixation or suspension of movable kidney (independent procedure)	175.00

Suture

3841	Nephrorrhaphy: suture of kidney wound or injury.....	175.00
3845	Closure of nephrostomy, pyclostomy or other renal fistula (ex: renal colic fistula).....	175.00
3846	Symphysiotomy for horse-shoe kidney.....	250.00
3847	Renal sympathectomy (independent procedure).....	175.00

URETER

Incision

3851	Ureterotomy with exploration or drainage (independent procedure)	175.00
3857	Ureterolithotomy	175.00

Excision

3861	Ureterectomy, complete or partial (independent procedure)	175.00
3867	Suprapubic excision (independent procedure).....	150.00

Repair

3871	Ureteroplasty: plastic operation on ureter (stricture)	225.00
3874	Ureteropyclostomy: anastomosis of ureter and renal pelvis	225.00
3876	Ureterocystostomy: anastomosis of ureter to bladder, unilateral	175.00
3877	bilateral	250.00
3880	Ureteroenterostomy: anastomosis of ureter to intestine, unilateral	200.00
3881	bilateral	300.00
3884	Ureterostomy: transplantation of ureter to skin, unilateral	175.00
3885	bilateral	225.00

Suture

3891	Ureterorrhaphy: suture of ureter (independent procedure)	175.00
3895	Closure of fistula of ureter.....	225.00

BLADDER

Incision

3900	Puncture aspiration of bladder by needle.....	15.00
3901	Cystotomy with exploration or fulguration.....	135.00
3902	Puncture aspiration by trochar.....	15.00
3906	Cystostomy with drainage.....	100.00
3907	Cystolithotomy	110.00
3908	Drainage of perivesical or prevesical space abscess.....	75.00

Excision

3911	Cystectomy, partial	200.
3913	complete	300.
3918	Transurethral electro-resection of vesical neck, female	50.
3920	Excision of bladder diverticulum (independent procedure)	150.
3922	Excision of bladder tumor (see 3901).	
3924	Transurethral resection of bladder tumors.....	125.

Endoscopy (independent procedure)

3931	Cystoscopy, diagnostic, initial.....	15.
3932	subsequent	15.
3933	with biopsy, initial.....	35.
3934	subsequent	35.
3935	with ureteral catheterization, initial.....	35.
3936	subsequent	35.
3937	with stone removal, manipulation, initial.....	75.
3938	subsequent	75.
3939	Ureteral meatotomy	50.
3940	Cystoscopy with fulguration of minor lesion of bladder	50.
3941	Cystoscopy with fulguration of bladder tumor, initial	50.
3942	subsequent	50.
3943	Cystoscopy with insertion of radioactive substance with or without biopsy or fulguration, initial.....	50.
3944	subsequent	50.
3945	Resection or fulguration of ureterocele.....	50.
3947	Cystoscopic removal of foreign body.....	50.

Destruction

3951	Litholapaxy: crushing of calculus in bladder and removal of fragments	75.
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Suture

3961	Cystorrhaphy: suture of bladder wound, injury or rupture	125.
3965	Closure of vesicovaginal, vesicouterine, or vesicorectal fistula	175.

URETHRA

Incision

3971	Urethrotomy, external (independent procedure)	60.
3973	perineal	100.
3975	Urethrostomy: drainage by fistulization (independent procedure)	100.
3977	Meatotomy: cutting of meatus (independent procedure)	15.
3978	Drainage of periurethral abscess.....	25.
	(See Integumentary System)	
3979	Drainage of perineal urinary extravasation (independent procedure)	100.

Excision

3981	Excision of urethral caruncle or fulguration.....	30.
3987	Excision of carcinoma of urethra.....	S/
3991	Excision of diverticulum of urethra (independent procedure)	100.
3994	Excision or fulguration of urethral polyps.....	30.

Endoscopy

4000	Urethroscopy, diagnostic	15.
4001	with removal of calculus or foreign body.....	25.
4004	with internal urethrotomy.....	35.
4006	with fulguration of posterior urethra.....	25.
4008	subsequent	25.

Repair

4011	Urethoplasty: plastic operation on urethra.....	140.00
4019	Diversion of perineal urinary extravasation with diversion of urinary stream.....	200.00

Suture

4021	Urethrorrhaphy: suture of urethral wound or injury	90.00
4023	Closure of urethrostomy or fistula of urethra (independent procedure)	90.00
4025	Closure of urethrovaginal fistula.....	110.00

Manipulation

4031	Dilation of urethral stricture by passage of sound, initial	40.00
4033	subsequent	40.00

Male Genital System

PENIS

Incision

4101	Dorsal or lateral "slit" of prepuce (independent procedure)	15.00
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Excision

4111	Biopsy of penis.....	15.00
4114	Amputation of penis, partial.....	110.00
4115	complete	175.00
4116	radical	225.00
4120	Local excision of lesion of penis.....	35.00
4122	Circumcision, newborn	5.00
4123	under age 10.....	25.00
4125	age 10 or over.....	25.00
4127	Excision (or fulguration) of warts 15.00 (max. 60.00 per year)	

Repair

4131	Plastic operation on penis for hypospadias, straightening of chordee	70.00
4132	Urethroplasty for hypospadias (see 0260 to 0319)	
4134	Plastic operation on penis for injury.....	S/R
4135	for epispadias	200.00
4138	Abscess, hematoma or extravasation.....	100.00

TESTIS

Excision

4141	Biopsy (independent procedure).....	25.00
4144	Orchiectomy, simple, unilateral.....	60.00
4146	radical, unilateral or bilateral, with retroperitoneal gland dissection	250.00

Repair

4152	Reduction of torsion of testis by surgical means.....	50.00
4156	Orchiopexy, with attachment of testis to thigh (Torek)	150.00
4157	with detachment of testis from thigh, second stage (Torek)	S/R
4158	one or more stages, with hernia repair.....	150.00

EPIDIDYMISS

Incision

4161	Drainage of abscess of epididymis.....	25.00
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Excision

4171	Biopsy of epididymis.....	25.00
4174	Excision of spermatocele without epididymectomy.....	60.00
4176	Epididymectomy, unilateral	75.00
4177	bilateral	125.00

Repair

EPIDIDYMOVASOSTOMY—Anastomosis of epididymis to vas deferens.

4181	unilateral	125.00
4182	bilateral	150.00

TUNICA VAGINALIS

Incision

4191	Puncture aspiration of hydrocele.....	10.00
4192	subsequent	10.00
4201	Excision of hydrocele, unilateral.....	60.00
4202	with hernia repair (see Hernioplasty).	

SCROTUM

Incision

4211	Drainage of scrotal abscess.....	15.00
4215	Removal of foreign body in scrotum.....	35.00

Excision

4221	Local excision of lesion of scrotum (see 0260 to 0319)	
4224	Resection of scrotum.....	S/R
4227	Scrotoplasty: plastic operation on scrotum.....	S/R

SPERMATIC CORD

Excision

4271	Excision of hydrocele of spermatic cord (independent procedure), unilateral	60.00
4272	bilateral	90.00
4275	Excision of varicocele (independent procedure), unilateral	60.00
4278	with hernia repair (see Hernioplasty).	

SEMINAL VESICLES

Incision

4281	Vesiculotomy, unilateral	S/R
4282	bilateral	S/R

Excision

4291	Vesiculectomy	225.00
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PROSTATE

Incision

4301	Prostatotomy: external drainage of prostatic abscess	60.00
4304	Prostatolithotomy: removal of prostatic calculus (independent procedure)	200.00
4305	Prostate—needle biopsy	15.00

Excision

4311	Prostatectomy, perineal, subtotal.....	200.00
4313	perineal, radical	300.00
4316	suprapubic, one or two stages.....	200.00
4318	retropubic	200.00
4319	(radical) not otherwise classified.....	300.00

Endoscopy

4321	Transurethral electro-resection of prostate, including control of post-operative bleeding, complete.....	200.00
4323	partial, initial	200.00
4324	partial, subsequent	75.00

Female Genital System

VULVA

Incision

4401	Episiotomy, non-obstetrical	15.00
4403	Incision and drainage of abscess of vulva.....	15.00
4405	Incision and drainage of Bartholin's gland abscess, unilateral	25.00
4411	Incision of hymen: hymenotomy.....	15.00

Excision

4421	Biopsy of vulva.....	15.00
4423	Vulvectomy, complete	150.00
4424	partial	100.00
4425	radical, including regional lymph nodes.....	300.00
4427	Local excision of lesion of external female genital organ (see 0178, 0260 to 0262)	
4428	Circumcision, female: clitoridotomy.....	15.00
4431	Excision of hymen: hymenectomy.....	20.00
4433	Excision or cautery destruction of Bartholin's gland or cyst	40.00
4436	Excision or fulguration of Skene's glands.....	25.00

Repair

4441	Episioplasty: plastic repair of vulva.....	S/R
4443	Plastic operation on urethral sphincter, female (Kelly, Kennedy)	85.00
4445	Plastic repair of female urethra for prolapse of mucosa (independent procedure)	S/R
4447	Repair of urethrocele, female (independent procedure)	50.00

Suture

4451	Episiorrhaphy: suture of recent injury of vulva.....	S/R
4455	Episioperineorrhaphy: suture of recent injury of vulva and perineum (non-obstetrical).....	S/R

VAGINA

Incision

4461	Colpotomy with exploration or drainage of pelvic abscess	40.00
4463	Puncture and aspiration of Douglas' cul de sac.....	30.00

Excision

4471	Biopsy of vagina (independent procedure).....	15.00
4473	Colpectomy or colpocleisis, complete; (complete obliteration of vagina).....	125.00
4474	partial (La Forte).....	125.00
4476	Excision of vaginal cyst.....	35.00
4478	Excision of vaginal septum.....	35.00

Repair

4481	Colpoplasty, anterior vaginal wall; repair of cystocele (independent procedure)	110.00
4482	with repair of urethrocele.....	110.00
4484	posterior vaginal wall; repair of rectocele (independent procedure)	90.00
4486	Colpoperineoplasty, posterior vaginal wall; repair of rectocele and perineoplasty; pelvic floor repair.....	90.00

4488	Anterior and posterior vaginal walls; repair of cystocele, rectocele, and perineoplasty.....	175.00
4491	with repair of urethrocele.....	175.00
4493	Repair of enterocele, with or without associated related procedures, abdominal approach.....	110.00
4494	vaginal approach	110.00
4495	Colpopexy	175.00
4497	Reconstruction of congenital deformities of the vagina including vaginal atresia and septate vagina.....	S/I

Suture

4501	Colporrhaphy: suture of recent injury of vagina (non-obstetrical)	S/I
4505	Colpoperineorrhaphy: suture of recent injury of vagina and perineum (non-obstetrical).....	S/I
4506	Closure of vaginal fistulae (see Ureter, Bladder, Rectum)	S/I

Manipulation

4511	Dilation of vagina (under anesthesia).....	15.00
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Endoscopy

4521	Culdoscopy (independent procedure).....	25.00
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OVIDUCT

Excision

4541	Salpingectomy, complete or partial, unilateral or bilateral (independent procedure)	125.00
4545	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (independent procedure).....	125.00
4551	Salpingoplasty for sterility, unilateral or bilateral (independent procedure)	125.00

Suture

4561	Ligation of fallopian tube, unilateral or bilateral (independent procedure)	125.00
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OVARY

Incision

4571	Drainage of ovarian cyst or abscess, unilateral or bilateral (independent procedure)	125.00
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Excision

4581	Excision of ovarian cyst, unilateral or bilateral (independent procedure)	125.00
4583	Oophorectomy, unilateral or bilateral (independent procedure), complete	125.00
4585	partial	125.00
4591	Oophoroplasty, unilateral or bilateral (independent procedure)	125.00

UTERUS AND CERVIX UTERI

Excision

4611	Biopsy of cervix (independent procedure).....	15.00
4613	Hysterectomy (with or without dilation and curettage and surgery on tubes, ovaries, ligaments, etc.)	
	sub-total.....	175.00
4614	Hysteromyomectomy: myomectomy; excision of fibroid tumor of uterus.....	125.00
4617	Panhysterectomy: total hysterectomy (corpus and cervix)	200.00
4621	Supracervical hysterectomy: subtotal hysterectomy	175.00
4624	Fundectomy, uterine: excision of fundus of uterus.....	175.00
4627	Radical hysterectomy for cancer (Wertheim).....	300.00
4631	Vaginal hysterectomy, with or without pelvic floor repair	200.00

532	Removal of cervical stump.....	150.00
534	Trachelectomy: cervicectomy: amputation of cervix (independent procedure)	75.00
537	Partial excision of cervix.....	50.00
541	Local excision of lesion of cervix (cauterization or conization) in hospital	20.00
544	Local excision of lesion of cervix in conjunction with dilation and curettage.....	45.00
546	Dilation and curettage of uterus (independent procedure)	25.00
547	for removal of uterine polyps.....	50.00
548	for miscarriage or abortion.....	35.00
549	for therapeutic abortion.....	50.00
551	for postpartum hemorrhage.....	35.00

Introduction

571	Insertion of radioactive substance into cervix, uterus or both, with or without biopsy or dilation and curettage	45.00
576	Injection of radiopaque contrast media.....	25.00

Repair

580	Hysteropexy (with or without dilation and curettage and surgery on tubes, ovaries, ligaments, etc.).....	110.00
581	with ventrosuspension: ventrofixation.....	110.00
583	with presacral sympathectomy with or without other surgery	150.00
585	with interposition operation (Watkins, Kennedy), with or without pelvic floor repair.....	175.00
587	with shortening of round ligaments.....	175.00
590	with shortening of endopelvic fascia: parametrial fixation (Manchester) with or without pelvic floor repair	175.00
592	with shortening of sacrouterine ligaments.....	175.00
594	Hysterosalpingostomy: anastomosis of tubes to uterus	150.00
596	Tracheloplasty: plastic repair of uterine cervix (Emmett)	75.00

Suture

5701	Hysterorrhaphy: suture of ruptured uterus (non-obstetrical)	150.00
5705	Trachelorrhaphy: suture of recent injury or laceration of cervix (non-obstetrical).....	S/R

Manipulation

5711	Dilation of cervix, instrumental (independent procedure), in hospital.....	25.00
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PERINEUM

Incision

5720	Perineotomy with exploration, drainage of abscess, etc. (see Integumentary System).....	80.00
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Repair

5731	Perineoplasty: plastic repair of perineum (independent procedure)	75.00
5734	in conjunction with vaginal operations (see Vagina, repair, 4481 to 4494)	S/R
5735	Repair of perineum and third degree laceration of the rectum	175.00

Suture

5741	Perineorrhaphy: suture of recent injury of perineum (non-obstetrical)	S/R
5745	Closure of perineal fistula.....	100.00

Maternity

FETUS AND FETAL STRUCTURES

Incision

4801	Classic cesarean section.....	110.00
4802	Low cervical (lower uterine segment) cesarean section	125.00
4803	Cesarean section and hysterectomy (Porro).....	200.00
4804	Extraperitoneal cesarean section.....	150.00
4805	Vaginal cesarean section.....	125.00

Excision

4811	Removal of extrauterine embryo (ectopic pregnancy), by laparotomy	125.00
4815	Removal of hydatidiform mole by dilation and curettage	50.00

Manipulation

Obstetric procedures:

4821	Obstetrical delivery, including ante partum and post partum care	155.00
4822	excluding ante partum and post partum care.....	75.00
4823	Ante partum Care	80.00
4824	First Trimester (first 14 weeks of pregnancy)	20.00
	(25% of total amount above.)	
4825	Second Trimester (next 13 weeks of pregnancy)	20.00
	(25% of total amount above.)	
4826	Third Trimester (after 27 weeks of pregnancy)	40.00
	(50% of total amount above.)	
4827	Obstetrical delivery (including post partum care).....	75.00
4828	Post partum care (performed by physician other than physician performing delivery).....	
	(1/10 of ante partum.)	
	Total amount	8.00
4829	Abdominal hysterotomy (obstetrical) (mole or previable fetus)	125.00
4850	Miscarriage or abortion before period of viability; no surgery	35.00
4851	after period of viability.....	75.00
4855	including dilation and curettage.....	35.00
4860	Therapeutic abortion by dilation and curettage of uterus	50.00
4870	Dilation and curettage of uterus for post partum bleeding	35.00
4878	Circumcision of newborn.....	5.00

Endocrine System

Incision

4904	Incision and drainage of thyroglossal cyst (infected), in hospital	30.00
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Excision

4911	Local excision of small cyst or adenoma of thyroid	125.00
4914	Thyroidectomy, total or complete.....	200.00
4917	subtotal or partial.....	150.00
4924	total or subtotal, for malignancy with neck dissection	300.00
4937	Recurrent thyroidectomy of thyroid remnant.....	175.00
4941	Excision of thyroglossal duct, cyst or sinus.....	125.00
4971	Parathyroidectomy or exploration for parathyroid.....	250.00
4972	Mediastinal exploration	175.00
4988	Adrenalectomy	250.00
4993	Excision of carotid body tumor.....	225.00

Nervous System

Incision

CRANIOTOMY—

5001	Trephination (or burr holes), exploratory, unilateral	125.00
5008	Decompression, orbital, unilateral or bilateral.....	225.00
5011	subtemporal	150.00
5015	suboccipital	150.00
5017	Osteoplastic craniotomy (other than operation for brain tumor)	250.00
5018	for intracranial vascular malformation.....	S/R

Excision

5020	Excision of portion of skull for osteomyelitis.....	S/R
5021	Laminectomy	225.00
5025	Hemilaminectomy, lumbar	225.00
5026	cervical	275.00
5027	dorsal	225.00
5031	Cranioplasty: plastic operation on skull with bone graft or metal or plastic plate.....	S/R

Repair

5036	Repair of encephalocele.....	175.00
5040	Repair of meningocele (spina bifida).....	200.00
5043	Repair of meningomyelocele.....	200.00
5048	Open reduction of fracture of skull, with elevation or removal of fragments (see Bones, Fractures), debridement of compound fracture of skull (see Bones, Fractures)	S/R

MENINGES AND MENINGEAL VESSELS

Incision

5051	Drainage of subdural, epidural or subarachnoid space for abscess or hematoma, cranial.....	200.00
5054	spinal	200.00
5057	Spinal puncture: lumbar puncture (independent procedure), initial, diagnostic with pressure readings.....	20.00
5060	Simple spinal puncture.....	10.00
5062	Cisternal puncture (independent procedure).....	25.00
5065	Drainage of lateral or sigmoid sinus for phlebitis or thrombosis	200.00

Excision

5071	Excision of meningeal tumor, cyst or aneurysm.....	300.00
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Introduction

5081	Encephalography (independent procedure).....	30.00
5084	Myelography (independent procedure).....	30.00
5085	Discogram	30.00
5087	Visualization of intracranial aneurysm by intracarotid injection of dye (independent procedure) with exposure of carotid artery.....	50.00
5091	without exposure of carotid artery.....	50.00

Repair

5101	Graft of dura.....	250.00
5105	Marsupialization of lesion of meninges (cyst or abscess)	150.00

BRAIN

Incision

5127	Drainage of brain abscess, primary tapping.....	200.00
5128	subsequent tapping in operating room.....	25.00
5129	subsequent tapping in hospital room or ward.....	25.00
5132	Removal of foreign body in brain.....	S/R

5133	Frontal lobotomy, bilateral by craniotomy.....	200.00
5134	unilateral by craniotomy.....	200.00
5138	Tractotomy (medulla, mesencephalon).....	275.00
5142	Ventricular tap	50.00
5145	Subdural tap, unilateral.....	50.00

Excision

5151	Excision of cortical scar.....	250.00
5154	Excision of brain cyst, neoplasm or abscess.....	300.00
5157	Excision of brain tissue; topectomy.....	300.00
5161	Excision of choroid plexus.....	250.00
5164	Excision of lobe of brain.....	300.00

Repair

5181	Ventriculocisternostomy by catheter: Torkildsen's operation (plastic tube polyethylene).....	200.00
5185	Marsupialization of lesion (cyst, abscess).....	175.00

SPINAL CORD AND NERVE ROOTS

Incision

5207	Chordotomy: tractotomy or division or transection of nerve tracts in cord (cervical-dorsal).....	200.00
5211	Rhizotomy: division or transection of nerve roots.....	200.00
5214	Decompression of spinal cord (by removal of hematoma, bone fragments)	225.00

Excision

5221	Excision of lesion of spinal cord (neoplasm, cyst).....	300.00
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PERIPHERAL NERVES, CEREBRAL NERVES AND GANGLIA

Incision

NEUROTOMY—Cutting, division or transection of nerve.

5240	Retrogasserian neurotomy: transection of sensory root, trigeminal nerve, transtemporal.....	250.00
5243	posterior fossa	250.00
5245	intramedullary	250.00
5250	Transection of trigeminal and glossopharyngeal nerve	250.00
5252	Transection of phrenic nerves (phrenicotomy).....	50.00
5253	Phrenicorrhaxis (crushing)	50.00
5254	Transection of spinal nerves.....	115.00
5256	Transection of occipital nerve.....	115.00
5258	Transection of vagus nerve; vagotomy; vagectomy (abdominal)	125.00
5263	Exploration of brachial plexus (independent procedure)	S/R

Excision

5270	Excision of peripheral neuroma, digit.....	75.00
5271	other superficial	100.00
5272	deep	150.00
5273	Resection of nerve, phrenicectomy.....	100.00
5277	Neurexeresis: avulsion of infraorbital nerve.....	50.00
5278	Obturator neurectomy, unilateral.....	100.00
5279	bilateral	125.00
5281	Avulsion of phrenic nerve; phrenicoexeresis.....	100.00
5282	Stoefel's neurectomy, unilateral.....	100.00
5283	bilateral	125.00

Introduction

5290	Injection of alcohol (intraspinal, paravertebral or paracranial), initial	35.00
5291	subsequent	35.00
5294	Injection of alcohol (second and third divisions for trigeminal neuralgia), initial.....	35.00

Nerve Block

8	Paravertebral block, lumbar or thoracic.....	25.00
0	Sympathetic block (cervical).....	25.00
2	Stellate ganglion	25.00
1	Brachial plexus block.....	25.00
2	Intercostal nerves	15.00
3	Lumbar, sacral and coccygeal nerves.....	25.00
4	Pudendal nerve	25.00
5	Splanchnic nerves	25.00
6	Ilioinguinal and iliohypogastric nerves.....	25.00
7	Sciatic nerve	15.00
8	Phrenic nerve	15.00
9	Other peripheral nerve.....	15.00

Repair

NEUROPLASTY—Plastic repair of nerve injury.

0	Major nerve, upper or lower arm or leg, old injury, including scar excisions, local advancements, etc.	200.00
1	recent injury or transplant.....	200.00
2	lysis or freeing from scar of intact nerve.....	100.00
3	Grafts or other unlisted procedures, major or minor nerves	S/R
1	Brachial plexus	S/R
0	Digital nerve, within digit, suture, lysis or free from scar (each additional, add 50%).....	75.00
3	Sensory nerves, hand or foot (excluding digits), suture, lysis or freeing from scar, or transfer (each additional, add 50%)	90.00
4	Motor branch, median or ulnar nerve, new or old injury	100.00

Neuro-anastomosis:

0	Spinal accessory-facial, hypoglossal-facial, spinal accessory-hypoglossal, or others unspecified.....	250.00
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VEGETATIVE NERVE SYSTEM

Excision

Sympathectomy:

1	Cervical, unilateral	125.00
2	bilateral	200.00
5	Cervicothoracic, unilateral	175.00
6	bilateral	250.00
1	Lumbar, unilateral	150.00
2	bilateral	250.00
5	Splanchnicectomy, unilateral	175.00
6	bilateral	250.00
0	Presacral neurectomy, hypogastric plexus.....	150.00

Eye

EYEBALL

Excision

01	Goniotomy, primary	135.00
02	secondary	100.00

Excision

11	Enucleation of eyeball (bulb or globe).....	125.00
12	with implantation of prosthesis.....	135.00
13	with movable implant, primary.....	135.00
14	secondary	150.00
17	Evisceration of eyeball.....	125.00
18	with implantation in scleral shell.....	135.00
31	Suture of eyeball for wound or injury.....	S/R
37	Peripheral fields, complete.....	15.00

CORNEA

Incision

5441	Keratotomy, any type.....	60.00
5443	Paracentesis of cornea (keratocentesis).....	30.00
5445	Removal of foreign body from surface of cornea.....	10.00
5447	with magnet	10.00
5448	under slit lamp.....	10.00

Excision

5451	Keratotomy, partial	125.00
5452	complete	125.00
5457	Pterygium	35.00

Introduction

5461	Tattoo of cornea, mechanical or chemical.....	125.00
5465	Curettage and cauterization of corneal ulcer.....	10.00
5466	Iontophoresis of corneal ulcer.....	10.00

Repair

5471	Keratoplasty: corneal transplant, lamellar.....	250.00
5472	partial or complete, penetrating.....	250.00

Suture

5481	Suture of perforated cornea.....	125.00
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SCLERA

Incision

5491	Sclerotomy, operative incision, with removal of intra-ocular foreign body (with or without magnet)....	150.00
5492	with removal of foreign body from anterior chamber (with or without magnet).....	150.00
5493	Removal of intra-ocular foreign body with magnet, without operative incision.....	125.00
5495	Sclerotomy, posterior (paracentesis).....	50.00
5496	Aspiration of anterior chamber.....	25.00

Excision

5501	Sclerectomy for glaucoma, with scissors, punch or trephination (Lagrange, Holth, Elliott).....	150.00
5503	Scleral resection, full thickness.....	175.00
5504	lamellar	175.00
5505	subsequent	150.00

Introduction

5511	Air injection into anterior chamber for chronic glaucoma	50.00
5515	Irrigation and air injection into anterior chamber for chronic glaucoma	50.00

Suture

5521	Suture of sclera for wound or injury.....	S/R
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IRIS AND CILIARY BODY

Incision

5531	Iridotomy	90.00
5532	with transfixion of iris; iris bombé.....	90.00

Excision

5541	Excision of lesion of iris.....	50.00
5544	"Complete" iridectomy; optical iridectomy; preliminary iridectomy	90.00
5546	Peripheral iridectomy	90.00

Destruction

5551	Diathermy of the ciliary body; cyclodiathermy.....	90.00
5552	Iridodialysis—repair	125.00

5553	Corelysis	150.00
5554	Cyclodialysis	125.00

Suture

5561	Repair of prolapsed iris with suture of perforated sclera or cornea	S/R
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Manipulation

5571	Iridotaxis (iridencleisis): stretching of iris (independent procedure)	150.00
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CRYSTALLINE LENS

Incision

5601	Dissection; needling of lens, primary.....	60.00
5602	secondary	30.00

Excision

5611	Extraction of lens, intracapsular or extracapsular, unilateral	200.00
5616	Removal of dislocated lens.....	250.00

VITREOUS

Incision

5622	Transplantation of vitreous.....	150.00
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RETINA

Repair

5631	Reattachment of retina, electrocoagulation, initial.....	200.00
5632	subsequent	200.00

OCULAR MUSCLES

Incision, excision and repair

5641	Myotomy, tenotomy, recession, resection, advancement or shortening of ocular muscles for strabismus, one or more stages, unilateral.....	125.00
5642	bilateral	175.00
5643	One muscle, initial.....	125.00
5646	subsequent	125.00
5647	Muscle transplant	175.00

ORBIT

Incision

5651	Orbitotomy with exploration.....	60.00
5652	with drainage of intraorbital abscess.....	75.00
5653	with removal of intraorbital foreign body.....	125.00
5662	Excision of lesion of orbit, benign or malignant.....	100.00
5664	Exenteration or evisceration of orbital contents.....	250.00
5667	with graft	250.00
5668	without graft	250.00

Introduction

5671	Orbital injection of alcohol for hemorrhagic glaucoma—or intractable pain.....	35.00
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Repair

5681	Plastic repair of orbit (see 0260 to 0325 and 0617 to 0622).	
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EYELIDS

Incision

5691	Blepharotomy with drainage of abscess of eyelid.....	25.00
5692	with drainage of Meibomian glands; hordeolum (stye)	15.00

5697	Recession of levator palpebrae muscle.....	175.00
5698	Resection of levator palpebrae muscle.....	175.00

Excision

5701	Blepharectomy (see 0260 to 0262).	
5702	incision or excision of Meibomian glands (chalazion), single	15.00
5703	multiple	30.00
5707	Excision of lesion of eyelid, malignant (see 0260 to 0296).	
5712	Epilation, electrolytic	10.00
5717	Excision of xanthoma (see 0260 to 0296).	

Repair

5721	Blepharoplasty: plastic repair of eyelid, with or without graft, any type (see 0260 to 0319).	
5723	Canthoplasty: plastic repair of canthus (see 0260 to 0319).	
5724	Plastic restoration of eyebrow (by graft) (see 0295 to 0319).	
5725	Tarsoplasty: plastic repair of tarsal cartilage (see 0265 to 0267).	
5726	Reposition of cilia base (see 0260 to 0276).	
5728	Cautery puncture for entropion or ectropion.....	40.00

Suture

5731	Blepharorrhaphy: suture of eyelid (see 0265 to 0267).	
5734	Tarsorrhaphy: suture of tarsal cartilage (see 0265 to 0267).	
5737	Canthorrhaphy: suture of palpebral fissure of canthus (see 0265 to 0267).	

CONJUNCTIVA

Incision

5741	Removal of foreign body from surface of conjunctiva	10.00
5742	embedded in conjunctiva.....	15.00
5743	Suture of conjunctiva.....	25.00

Excision

5751	Biopsy of conjunctiva.....	10.00
5753	Excision of lesion of conjunctiva: cyst.....	35.00
5754	epithelioma (see 0260 to 0262).	
5755	nexus (see 0260 to 0262).	

Repair

Conjunctivoplasty:

5771	Free graft of conjunctiva (see 0295 to 0296).	
5773	of mucous membrane (see 0295 to 0296).	
5774	Flap operation for corneal ulcer.....	50.00
5775	Flap operation; "flapping" of conjunctiva for perforating injuries or operative wound.....	50.00
5776	for laceration	50.00
5777	Repair of symblepharon without graft (see 0260 to 0262).	

LACRIMAL TRACT

Incision

5801	Drainage of lacrimal gland (abscess).....	20.00
5803	Drainage of lacrimal sac—dacryocystotomy: dacryocystostomy	20.00
5804	Dacryocystotomy: dacryocystostomy, intranasal.....	20.00

Excision

5811	Excision of lacrimal gland: dacryoadenectomy.....	125.00
5813	Excision of lacrimal sac: dacryocystectomy.....	125.00
5815	Excision of lacrimal gland tumor.....	125.00

Introduction

5821 Catheterization of lacrimonasal duct, initial.....10.00

Repair

5831 Plastic operation on canaliculi.....S/R
5833 Dacryocystorhinostomy: fistulization of lacrimal sac into nasal cavity, with or without anterior ethmoidectomy (Toti) 175.00
5835 Closure of puctum by cautery.....15.00

Manipulation

5841 Dilatation of punctum.....15.00
5843 Probing of lacrimonasal duct, initial.....10.00
5844 subsequent 10.00 (max. 50.00)
5845 under general anesthesia.....25.00

Ear

EXTERNAL EAR

Incision

5901 Drainage of abscess of auricle (see 0103).....20.00
5903 Drainage of hematoma of auricle.....20.00
5905 Drainage of abscess of external auditory canal.....20.00

Excision

5911 Biopsy of ear.....15.00
5914 Local destruction of lesion of ear (see 0178).
5915 with plastic closure (see 0260 to 0319).
5917 Complete excision of ear: amputation of ear.....90.00
5922 Excision of exostosis of external auditory canal.....75.00
5924 Radical excision of malignant lesion of external auditory canal 175.00
5926 with neck dissection.....S/R

Endoscopy

5931 Otoscopy with removal of foreign body in external auditory canal 15.00
5933 under general anesthesia.....25.00

Repair

5941 Otoplasty: plastic operation on ear (see 0260 to 0319).

5943 Reconstruction of ear with graft of skin or cartilage (see 0260 to 0319 and 0619 to 0622).

Suture

5951 Suture of wound or injury of ear (see 0265 to 0267).

MIDDLE EAR

Incision

5963 Myringotomy: tympanotomy; plicotomy, under general anesthesia in hospital.....10.00

Excision

5971 Mastoidectomy, simple 150.00
5975 radical 250.00
5980 Exenteration of air cells of petrous pyramid, including radical mastoidectomy S/R
5983 Removal of middle ear polyp by snare, in hospital.....25.00
5984 Ossiculectomy 65.00

Repair

5991 Revision of radical mastoid cavity.....100.00

Suture

6001 Closure of fistula mastoid.....25.00

INTERNAL EAR

Incision

6011 Labyrinthotomy, any type.....250.00

Excision

6021 Labyrinthectomy 300.00

Repair

6031 Fenestration of semicircular canals.....300.00
6032 Revision of fenestration operation.....200.00
6033 Stapes mobilization 150.00

Auditory Examination:

6050 Audiometer testing, any method.....10.00
6052 Barany vestibular test.....15.00

ANESTHESIA AND ASSISTANTS

Fees for anesthesia and assistants are to be reported under the code for the surgical procedure to which related.

Anesthesia by physician to include inhalation, spinal, nerve block, and intravenous—based on anesthesia time which is defined as from the induction until end surgery—

First half hour.....20.00

Third and fourth quarter-hour (or major fraction thereof), each 5.00
Each succeeding quarter-hour (or major fraction thereof) 5.00

For information regarding assistants' fees, see Page 4, SURGERY, GENERAL INFORMATION, Paragraph 6.

RADIOLOGY

X-ray, Diagnostic

HEAD AND NECK

7000 Cerebral angiography 25.00
7002 Encephalography 35.00
7005 Ventriculography 35.00

7007 Eye for foreign body.....15.00
7008 Eye for localization of foreign body.....25.00
7010 Mandible 15.00
7012 Mastoids 20.00
7015 Facial bones 15.00
7016 Nasal bones 15.00
7018 Optic foramina 20.00

7020	Paranasal sinuses, regular.....	15.00
7022	contrast study	25.00
7024	Sella turcica	20.00
7026	Skull, complete study.....	20.00
7027	partial study	20.00
7028	complete, including paranasal sinuses.....	35.00
7030	Teeth, single area.....	5.00
7031	partial examination	10.00
7032	complete examination	15.00
7033	Temporomandibular joints	15.00
7035	Neck for soft tissues.....	15.00
7037	Sialography	20.00
7038	contrast study	25.00

CHEST

7100	Single PA, teleroentgenogram or other.....	15.00
7101	Complete—stereoscopic postero-anterior, other positions as indicated, with fluoroscopy where indicated.....	15.00
7102	Kymography	25.00
7103	Special body section radiography.....	25.00
7104	Bronchography	25.00
7105	including installation of contrast substance.....	40.00
7107	Angiocardiography	35.00
7108	Fluoroscopy	15.00
7110	Ribs	20.00
7112	Sternum	15.00

SPINE AND PELVIS

7201	Spine, complete	40.00
7204	cervical	15.00
7206	cervical, special oblique and flexion studies.....	20.00
7207	thoracic	15.00
7210	lumbosacral	15.00
7211	with obliques	20.00
7214	sacro-coccygeal	15.00
7215	lumbosacral, including pelvis.....	30.00
7217	Pelvis, including hips.....	30.00
7219	with lateral, both hips.....	40.00
7220	Sacro-iliacs	20.00
7225	Myelography	25.00
7227	Discogram	25.00

UPPER EXTREMITIES

7250	Clavicle	15.00
7251	Scapula	10.00
7252	Shoulder	10.00
7253	Humerus, including one joint.....	10.00
7254	Elbow	10.00
7255	Forearm, including one joint.....	10.00
7256	Wrist	10.00
7257	Hand	10.00
7258	Fingers	10.00

LOWER EXTREMITIES

7300	Hip	10.00
7301	complete, multiple positions	30.00
7302	studies during operative procedures.....	25.00
7303	Femur, including one joint.....	10.00
7304	Knee	10.00
7305	Leg, including one joint.....	10.00
7306	Ankle	10.00
7307	Foot	10.00
7308	Toes	10.00

ABDOMEN

7350	Plain film study.....	15.00
7351	Special studies, such as in passage of Miller-Abbott tube, etc.	35.00
7352	Fistula examination with contrast media.....	25.00
Gastro-intestinal tract:		
7356	Esophagus	15.00
7357	Small bowel studies.....	35.00
7358	Upper gastro-intestinal tract.....	35.00
7360	Colon by barium enema.....	25.00
7361	by barium enema and double contrast.....	25.00
7363	Gall bladder, plain.....	20.00
7364	cholecystography	20.00
7365	Cholangiography, operative or postoperative.....	20.00
7366	including intravenous opaque.....	25.00

Urological:

7370	Kidney, ureter and bladder, plain film.....	15.00
7372	Pyelography-intravenous	25.00
7373	retrograde	25.00
7375	Cystography	15.00
7377	Urethrocytography	20.00

Gynecological and obstetrical:

7380	Abdomen and pelvis, plain for fetus.....	20.00
7383	Pelvicephalometry	25.00
7385	Placentography	20.00
7387	Hysterosalpingography, including injection of opaque media	20.00
7388	injection by referring physician.....	15.00

SPECIAL STUDIES

7450	Reduction of fractures—fluoroscopic assistance.....	15.00
7452	Localization of foreign body (excepting eye), fluoroscopy and film as indicated.....	25.00
7453	Foreign body removal—fluoroscopic assistance.....	25.00
7456	Bone age studies.....	25.00
7457	Bone length studies (orthoroentgenogram).....	20.00
7458	Bone survey	40.00

Angiography:

7460	Arteriography	25.00
7461	Venography	20.00
7462	Pneumo-arthrography (or opaque).....	20.00
7463	Fistula or sinus injection with contrast—trunk.....	25.00
7464	Mammography	25.00
7466	Body section radiography.....	25.00
7470	Aortography	25.00
7471	including injection of opaque material.....	35.00
7478	Consultation on x-ray examination made elsewhere.....	15.00

Radiotherapy

(X-RAY—Radium or Radioactive Isotopes, including provision of Radiation sources)

PROVEN MALIGNANCY OR TUMORS

Fees for complete course of treatments of any required number

Head and Neck

7500	Brain, including pituitary.....	400.00
7502	Oral cavity	325.00
7504	Orbit	400.00
7506	Nasopharyngeal	400.00

510	Larynx—intrinsic, extrinsic, cancer, complete course (curative)	325.00
514	Thyroid	400.00

chest

522	Mediastinum	400.00
524	Pleura	400.00

abdomen

Gastro-intestinal tract:

530	Esophagus	400.00
532	Stomach	135.00
534	Small intestine	135.00
540	Colon	275.00
542	Rectum	400.00
544	Anus	400.00

Genito-urinary tract:

550	Kidney	325.00
556	Bladder, cancer, complete course	325.00
558	Testicle	400.00
560	Prostate	325.00
563	Penis	275.00

Gynecological tract:

570	Ovaries	400.00
572	Fallopian tubes	400.00
574	Uterus corpus	400.00
576	cervix, complete course radium and x-ray	400.00
578	Vagina	400.00
580	Vulva	400.00
582	Peritoneum	400.00

breast:

590	Preoperative	200.00
592	Postoperative	200.00
594	Primary (radiotherapy only)	300.00
596	Recurrent, chest wall	150.00
598	Metastases	150.00

bone:

600	Primary	275.00
604	Metastatic, one area	135.00

Miscellaneous:

7610	Leukemia, maximum per annum	400.00
7612	Hodgkins, maximum per annum	400.00
7614	Lymphosarcoma, fibrosarcoma, neurosarcoma, and other soft tissue sarcomas, maximum per annum	400.00
7616	Spinal cord lesions	400.00
7618	Polycythemia vera	135.00

Superficial:

7620	Skin neoplasm up to three cm. diameter	100.00
7622	Lip	135.00
7624	Lymph node metastatic	150.00
7626	Endocrine system, pituitary, adrenal	135.00
7638	Single high voltage treatment	25.00
7639	Consultation on therapeutic procedures	25.00

NON-MALIGNANT DISEASES

7642	Adenitis, single treatment	15.00
7644	Angioma	20.00
7646	Arthritis, periartthritis	40.00
7650	Bursitis, course	50.00
7652	Carbuncle, per treatment	15.00
7654	Cellulitis, per treatment	15.00
7656	Dermatitis	40.00
7657	Infection, course	40.00
7658	Endometriosis	135.00
7660	Enteritis, regional	135.00
7664	Fibroids	135.00
7666	Fungus infections, per treatment	10.00
7668	Furuncle, per treatment	15.00
7670	Keratosis, per treatment	15.00
7672	Keloid, per treatment	15.00
7674	Hyperthyroidism	325.00
7676	Menorrhagia, metorrhagia	135.00
7678	Lymphoid tissue	50.00
7680	Ovarian dysfunction	75.00
7682	Paronychia, per treatment	10.00
7684	Parotitis, per treatment	15.00
7686	Pruritus, per treatment	15.00
7688	Tinea capitis, full course	75.00
7690	Syringomyelia, full course	275.00
7692	Verucca, per treatment	15.00
7698	Single low voltage treatment	10.00

PATHOLOGY

Pathological Examinations

BLOOD

602	Agglutinations, for febrile diseases, first antigen	3.00
603	each additional	1.50
604	Alcohol, blood	7.50
605	Amylase, blood	7.50
606	Antistreptolysin titer	5.00
608	Ascorbic acid	5.00
609	Basophilic aggregates (L-E cells)	5.00
611	Bilirubin (Van den Bergh)	5.00
614	Bleeding time	1.00
617	Blood culture, aerobic and anaerobic	5.00
618	definitive	4.00
620	Blood, red cell count	1.50
622	hemoglobin determination	1.00
624	white cell count	3.00
8626	differential count	2.00
8628	complete count	5.00
8634	Bone marrow, collection and examination of material	30.00
8636	examination of material	15.00
8637	Bromides	5.00
8638	Bromsulphalein	7.50
8640	C-reactive protein	5.00
8641	Calcium	5.00
8643	Carbon dioxide combining power	7.50
8644	Congo red	5.00
8646	Cephalin flocculation	5.00
8647	Arterial puncture	5.00
8648	CO ₂ content arterial blood	10.00
8650	Chlorides	5.00
8652	Cholesterol	5.00
8654	Cholesterol ester	7.50
8656	Clot retraction	1.00

8658	Coagulation time (Lea & White).....	2.00
8659	other methods	1.50
8661	Complement fixation tests (Wassermann, etc.).....	2.00
8662	Complement fixation, quantitative.....	2.00
8664	Creatinine	5.00
8665	Creatinine clearance	7.50
8666	Creatine	5.00
8667	Electrophoresis pattern, protein.....	10.00
8668	lipoprotein	10.00
8671	Eosinophile count	3.00
8675	Flocculation tests (Kline, Kahn, etc.), each.....	2.50
8677	Hemoglobin, carbon monoxide.....	5.00
8678	methemoglobin	5.00
8679	sulphemoglobin	5.00
8681	Hematocrit	1.50
8684	Heterophile antibody with absorption.....	7.50
8685	without absorption	5.00
8688	Oxygen saturation, arterial blood.....	10.00
8689	pH (arterial blood).....	10.00
8690	Icterus index	2.50
8691	Lead	15.00
8692	Lipase	7.50
8693	Lipids, total	5.00
8694	Lipids, phospho	5.00
8695	Non-protein nitrogen	5.00
8697	O ₂ Content (arterial blood).....	10.00
8698	Blood oxygen	10.00
8699	Oxycorticoids	15.00
8700	Phosphatase, acid	7.50
8701	alkaline	7.50
8702	Phosphorus	5.00
8703	pH blood	10.00
8704	Platelet count	3.00
8706	Potassium	7.50
8707	Protein bound iodine.....	10.00
8708	Prothrombin time, first three, each.....	5.00
8709	subsequent, each	3.00
8710	Prothrombin utilization	7.50
8711	Red cell fragility.....	5.00
8713	Reticulocyte count	3.00
8716	Rh titer	5.00
8720	Sedimentation rate	1.50
8722	Smears for parasites (malaria, etc.)	3.00
8724	Sodium	7.50
8726	Sugar	2.50
8728	Sugar tolerance, 3 hours.....	12.50
8729	5 hours	15.00
8731	Thymol turbidity	5.00
8733	Total protein	5.00
8734	and albumin globulin ratio.....	10.00
8735	Albumin and globulin ratio.....	5.00
8737	Typing blood	2.00
8738	Rh	2.00
8739	Coombs technique	3.00
8740	Crossmatch saline and albumin.....	3.00
8741	Urea	5.00
8743	Urea clearance	10.00
8746	Uric acid	5.00
8748	Vitamin A	10.00
8750	Volume, blood (dye method).....	5.00
8751	Radio isotope	S/R

FECES

8800	Occult blood	1.00
8801	Routine chemical, fat.....	1.00
8802	starch	1.00
8803	Routine microscopic, wet preparation (parasites).....	4.00

8804	Iron hematoxylin stain.....	4.00
8805	Routine chemical and microscopic examination, including parasites	10.00
8806	Routine to include complete chemical and microscopic (series of three).....	20.00
8809	Quantitative urobilinogen	10.00
8813	Culture for bacteria, screening.....	5.00
8814	definitive	10.00

GASTRIC OR DUODENAL CONTENTS

(Includes Aspiration)

8820	Gastric contents, sterile technique.....	5.00
8821	microscopic	3.00
8824	chemical, acid, single.....	3.00
8827	chemical, acid, fractional.....	10.00
8828	chemical, acid, fractional, with histamine.....	10.00
8829	chemical, pepsin	15.00
8830	tubeless	10.00
8831	Duodenal contents, microscopic.....	3.00
8835	enzyme determination as ordered, each.....	7.50
8841	Smear for TB, concentrated.....	5.00
8844	Culture for TB, concentrated.....	7.50

SPINAL FLUID

8851	Spinal fluid collection.....	10.00
8853	Routine chemical (Pandy).....	1.00
8855	Routine microscopic (cell count).....	1.50
8857	Routine chemical and microscopic.....	10.00
8861	Colloidal gold (mastic, carbon, etc.).....	3.00
8866	Complement fixation tests for syphilis.....	3.00
8871	Smear for bacteria.....	2.00
8873	Culture for bacteria screening.....	3.00
8874	definitive	10.00
8878	Quantitative chemical tests (see Blood).	

SPUTUM

8881	Smear, direct	2.00
8884	after concentration	5.00
8890	Culture for tubercle bacilli.....	4.00
8891	Culture, direct screening.....	3.00
8892	direct definitive	10.00
8894	after concentration	5.00
8895	for fungus	5.00

TISSUES

8901	Surgical, gross only.....	2.50
8903	gross and microscopic.....	7.50
8907	frozen section (includes permanent section).....	17.50
8911	culture for bacteria screening.....	5.00
8912	culture for bacteria, definitive.....	10.00
8917	Cytologic study (Papanicolaou smear).....	7.50
8918	gastric or pepsin.....	20.00

URINE

8930	Routine chemical, qualitative.....	1.50
8931	Quantitative sugar	1.00
8932	Routine microscopic	2.00
8933	Bence-Jones protein	1.00
8934	Complete routine (chemical and microscopic).....	3.00
8935	Quantitative functional (Addis).....	5.00
8936	Concentration and dilution tests.....	2.00

37	Sugar fermentation	1.00	8966	blood	10.00
38	Phenosulfonphthalein	5.00	8967	Urinary 17-ketosteroids	12.50
39	Porphyrins, qualitative	5.00	8968	11-oxysteroids	15.00
40	quantitative	12.50	8969	gonadotropins	15.00
41	Smear for bacteria.....	2.00	8970	Residual air determination.....	S/R
42	Porphobilinogen	2.00	8971	Bronchospirometry (see 2126).	
43	Culture for bacterial screening.....	3.00	8972	Exclusion test for pheochromocytoma (Regitine, etc.)	7.50
44	Lead, quantitative	15.00	8973	Direct smear without stain.....	2.00
45	Culture for bacteria, definitive.....	5.00	8974	Miscellaneous smear for bacteria with stain.....	2.00
46	Quantitative calcium (Sulkowitch).....	1.50	8976	Miscellaneous culture for bacterial screening.....	3.00
47	Bile pigments	1.00	8977	Guinea pig for Tbc.	7.50
48	Quantitative chemical examination (see Blood).		8978	Miscellaneous animal inoculation for bacteria.....	7.50
49	24-hour calcium	5.00	8979	Miscellaneous culture for bacteria definitive.....	10.00
			8983	Vital capacity	3.00
			8987	Skin tests with bacterial extracts (each) (Brucella, Frei, Tuberculin, etc.)	4.00
			8988	Venous pressure.....	5.00
			8989	Circulation time	5.00
			8991	Stone analysis, qualitative.....	5.00
			8992	quantitative	15.00
			8994	Transudates and exudates, microscopic (see 8903).	
			8995	Culture screening	5.00
			8996	definitive	10.00
			8997	Animal inoculation	12.50
			8998	Chemical (see Blood).	
			8999	Ventilation studies, complete (respirometer), including spiogram, timed vital capacity, maximal breathing capacity, with interpretation and report.....	15.00

MISCELLANEOUS

50	Electroencephalogram	25.00
51	Antibiotic sensitivity, per antibiotic (pyrogenic).....	4.00
52	Antibiotic sensitivity (Tbc.).....	5.00
53	Autogenous vaccine	15.00
56	Basal metabolic rate	5.00
57	Electrocardiogram, with interpretation and report.....	10.00
58	without interpretation and report.....	5.00
59	interpretation and report only (tracing not done by interpreting physician)	5.00
60	exercise test, with interpretation and report.....	15.00
61	Biologic test for pregnancy (A-Z, Friedman, etc.).....	7.50
62	(Frog)	3.00
65	Darkfield examinations, skin lesion.....	10.00

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FOUND! THE RECORD OF THE 1767 MEDICAL SOCIETY IN LITCHFIELD

BYRON STOOKEY, M.D., *Sharon*

It has long been known that a medical meeting was held in the Simeon Smith house in Sharon, Connecticut on July 5, 1779. Baffling suggestions of an earlier meeting in 1767 had been referred to from time to time. My interest in the subject was aroused some twenty years ago when we bought the Simeon Smith house, the garret of which had been filled with papers of the Smith family, who occupied the house from 1765 until 1915.

At that time I procured a photostatic copy of the announcement of the July 5, 1779²⁴ meeting of the Medical Society of Sharon, and a photostatic copy of the oration of Dr. James Potter²⁶ delivered at a subsequent meeting on the last day of February, 1780, both of which took place in the Smith house. Simeon Smith was one of the founders of the 1770 society and, as I now find, of the 1767 meeting.

Tantalizing and elusive references to an earlier medical meeting held in Litchfield in 1776 have long intrigued many interested in the subject, notably Bronson,³ Bacon,¹ Steiner,²⁹ Barker,² and Burr.⁵ Bacon called the extant accounts "rather dim and legendary," most references seemed dubious of its existence or felt that, at best, a single meeting had taken place. I have followed a number of leads from time to time without success, yet always hopeful. In Dr. Potter's 1780 Sharon oration, the first elusive reference to a previous meeting is made. He reminded his listeners that "about fourteen years ago I exhibited before The Medical Corporation of Litchfield a compendium of the first rise and progress of Physic." If this statement is accepted, the earlier meeting took place about 1766. A reference to the earlier meeting is found some seventy years later in Judge Samuel Church's⁶ address at the Litchfield

The Author. *Emeritus Professor of Neurological Surgery, Columbia University College of Physicians and Surgeons*

County Centennial celebration held in Litchfield in 1851. Church listed ten of the physicians who were present at this meeting and gave the bare statement that the meeting took place. The source of his information has been a mystery to all who searched the available records, yet the statement was so definite it was felt that somewhere, sometime, data confirming his remarks must eventually be found.

Kendall²⁵ believed the Litchfield meeting to have taken place in 1764. Sumner,³⁰ 1765, while Russell²⁷ gave the date as 1766, but no evidence was given in support of their statements. I have been unable to gather any information to confirm the dates of 1764, 1765 or 1766 for the Litchfield meeting.

Dr. Kendall, who practised in Norfolk, says that "We doctors of Litchfield County who live on the Taconic Range and on its spurs, know our founders never rode their horses through the snows and the cold and the winds of January to found a medical society." Living now on the spurs of the Taconic Range myself I may say it would be a hardy individual who would undertake this journey, yet such journeys were far from uncommon even in winter. John Cotton Smith rode horseback from Yale to return home for Thanksgiving with his Uncle Simeon in Sharon in 1779, carrying two oranges in his saddle bags for his two grandmothers and, as Helen Fvertson Smith²⁸ says, "though he left on Monday morning and rode with all due diligence considering the snow, he did not arrive till late

Read before the Beaumont Medical Club, New Haven, Connecticut, January 18, 1957

Wednesday, and alas the oranges were frozen in his saddle bags." Physicians seeking knowledge, and associations with each other, and the opportunity to discuss their difficult diagnostic problems would not find the weather an insurmountable obstacle. Our forebears were made of sterner stuff. Furthermore we do know that one of the meetings in Sharon took place the last day of February, 1780, and February can be cold in Sharon, thus January, 1767 did not seem an impossible date.

Lately I have been spurred on in my search by the gracious invitation of Dr. John Fulton. I am glad to report that I have finally discovered definite proof



FIGURE 1

Simeon Smith house in Sharon, built in 1765. The only remaining building in which the early meetings took place, now the home of Dr. Byron Stookey. (Photograph courtesy Dr. H. Thoms)

that a meeting actually took place in Litchfield in January, 1767, the weather notwithstanding. Thirty-one physicians attended, two of whom were examined and welcomed to membership, and a code of professional ethics was adopted.

In view of the fact that up to this time no substantiating evidence of the existence of this society has been brought forth, and since this was apparently the first medical society in the colony which had a recorded history of effort over a period of years, it would seem desirable to publish the details of its formation, its efforts to improve the practise of physic and surgery, as well as the attacks against it, so that these historical facts may, in future, be

available to the medical profession and to students of colonial times.

The first meeting of The Medical Corporation* in Litchfield took place in the Court House in Litchfield, Connecticut on the second Tuesday of January, 1767. Unfortunately the first two Court Houses were destroyed by fire, consequently the only building remaining in which the early medical meetings took place is the Simeon Smith house in Sharon. (Figure 1.) The transactions of this first meeting were published in the *Connecticut Courant*⁷ of February 23, 1767 (Figure 2.):

M. Green,

By giving the following a Place in your next, you will certainly oblige some, and 'tis hoped, not disoblige any of your Friends and good Customers.

The Object of Physic, in the human Body, according to the incomparable Boerhaave, is Life. Health, Disease and Death, with the Causes from whence they arise, & the Means by which they are to be regulated, restored or prevented. Physic is therefore the Science or Knowledge of those Things, by whose Application and Effects. Health may be preserved when present, and restored when lost. Hence the Necessity, Usefulness and Dignity, are sufficiently apparent. From mature Consideration whereof, the Practitioners in Physic and Surgery in Litchfield County, were induced to convene and incorporate by the Name of, The medical Corporation in Litchfield County. And after being properly organiz'd, by choosing a President, Clerk, etc. unanimously came into the following Resolves, viz.

I. We the Subscribers, Members of the Medical Corporation in Litchfield County, do covenant and engage, to end, with each other; that (acting on the Principles of Honor, Honesty and Fidelity) we will trust one another, in our Professions or Practice, that may tend to the Hurt or Detriment of any Member of this Corporation, either in the Interest or Character, whereby Contempt or Reproach may be brought on worthy Practitioners, and true medical Knowledge. And any Member who shall be found guilty of a Violation of the above Engagement, after a fair Trial, and refusing to heal and accommodate the same, shall be deemed unworthy to be continued a Member of this Corporation, and denied all the Privileges and Benefits of the same.

II. That for the future, all and every Candidate for Practice, either Apprentice to any Physicians, or Surgeon within this County, or Stranger, or

*Corporation is used here in its earlier sense meaning a body of persons.

Foreigner, coming into the County, shall submit himself to an Examination by this Corporation, or a Committee chosen and appointed for that Purpose, by the Corporation, and abide their Determination (unless such Stranger or Foreigner shall be able to produce sufficient Credentials of his Knowledge and Skill in Physic or Surgery, according as he shall profess) on Pain of the highest Displeasure and Neglect (as Practitioners in either of the above-mentioned Arts) of all and every Member of this Corporation.

III. That any reputable Physician, or Surgeon, belonging to any other County within this, or any other Government, upon proper Application and Desire, shall be admitted a Member of this Corporation, and entitled to all the Privileges and Immunities of the same, upon Condition of his conforming himself to the Rules and Orders made, established and observed by the Corporation.

IV. That (if found necessary) a Committee shall be chosen and appointed, to whom Candidates for Admission to Practice may apply, and be examined: And said Committee shall make Report of the Performances of such Candidate, or Candidates to the Corporation, for their Acceptance or Disapprobation.

V. That when any Candidate for Practice has been examined as aforesaid, and admitted, a Certificate thereof shall be given or presented to him signed by the President, in the Name and Behalf of the Corporation and attested by the Clerk.

VI. That it shall be the Duty of every Member, carefully and duly to observe and minute every rare and uncommon Occurrence, either in the Phenomenon of Diseases, or Operation of Medicines, and communicate the same, together with his Sentiments of the Cause, and the Methodus Medendi which succeeded, to the Relief of the Patient (if any) but if altogether at a Loss how to account for the Appearance, shall (after having given a regular History thereof) have Liberty to propound it to the Corporation by way of Query, for their Consideration and Discussion.

VII. That it be recommended to each and every member of this Corporation, as a Thing desirable, and greatly tending to the Advancement of true medical Knowledge; that they may make at each Convention, a short Dissertation upon some one of the several Branches of Physic or Surgery upon solid and true philosophic Principles.

VIII. That this Convention shall be held at the Court-House in Litchfield, twice in a Year, viz. On the second Tuesdays of June and January, at one of the Clock in the Afternoon on said Days, and that the President and Clerk shall be chosen annually at our Convention in January.

March, 1957

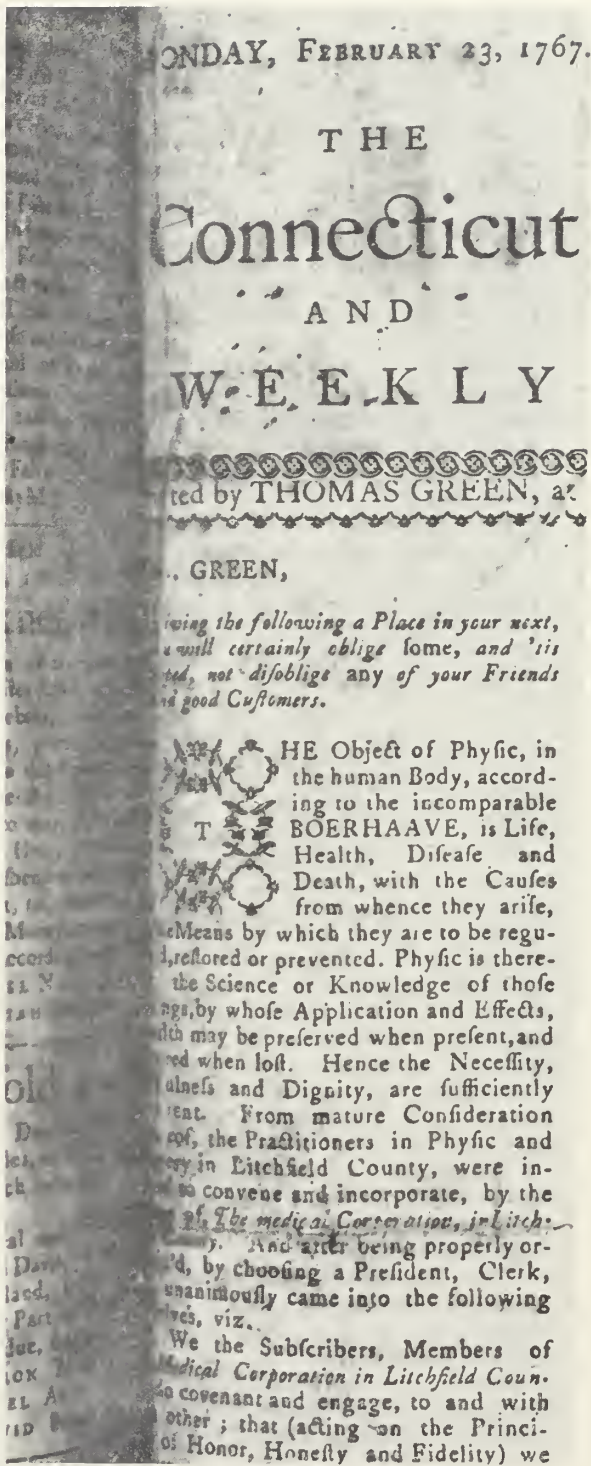


FIGURE 2
Photostatic copy of part of the report of the first meeting of The Medical Corporation in Litchfield, on the second Tuesday in January, 1767

Subscribed by,

Timothy Collins, esq;	Ebenezer Mann
Cyrus Marsh, esq;	Ephraim Guitteau x
*Agur Tomlinson, esq;	Joel Soper
Joshua Porter, Esq.	Joseph Hopkins
*Benjamin Warner,	George Hard
Joseph Perry, x	John Spalding
Andrew Graham	Lionel Wheeler
John Meigs	John Calhoun
Seth Bird	Oliver Fuller
Elisha Sill	Abiram Pott
Elisha Baker	Samuel Catlin
John Carrington	Benjamin Hawley
Simeon Smith	Reubin Smith
William Abernathy	*Ebenezer Beardsley
*James Potter	Thomas Ranney
*Erastus Sergeant	

Since the foregoing Resolves, the Corporation have thought proper, and accordingly appointed, at each Convention, a certain Number to prepare Dissertations against the next; and also determined that the Examination be performed before the Corporation, by Examiners chosen at each Convention, for that Purpose. In Consequence of these Resolutions, two young Gentlemen, viz. Ebenezer Beardsley and Thomas Ranney, offered themselves at our last Meeting in January, were examined, accepted and made free of this Corporation.

And as the Corporation was influenced to these Measures principally from Motives of public Good, they would humbly hope to meet the Smiles and Approbation of the Public; and that Gentlemen of the Faculty, of superior Abilities, in other Parts of the Colony, will candidly accept and improve on these Hints, or strike out some better and more effectual Method to advance medical Knowledge; and discountenance the Growth and Increase of Ignorant Pretenders to the healing Art.

N.B. Those Gentlemen that have an Asterism (*) prefixed to their Names, belong out of the County,

Thus at the first meeting twenty-nine members were present, four of whom came from outside the county. Ebenezer Beardsley, one of the candidates for examination, came from Waterbury. He subsequently moved to New Haven where he stood at the head of his profession and became one of the original signers of the January 5, 1784 New Haven petition and a member of the committee to form further regulations to be laid before their next meeting.

At the second meeting of The Medical Corporation, on the second Tuesday of June 1767, Seth Bird of Litchfield presented a dissertation on mercury,

and Oliver Fuller an oration "for the instruction of new members." (Figure 3.) Fortunately for us, both the dissertation and the oration were printed in the *Connecticut Courant*,^{8,9} September 7 and 14, 1767.*

At a Convention of the Medical Corporation, in Litchfield County, at Litchfield, on the second Tuesday in June last. Thomas Russell, esq; of Cornwall, who had met before with the Corporation, was pleased to join and incorporate. Also Mess. Francis Forgue of Fairfield in Fairfield County, Hosea Hulbert and John Crane, both of Waterbury, in New Haven County, being Personally present, were made free of the Corporation. After which Mr. Seth Bird entertained the Corporation with a Dissertation on Mercury, which was followed by a short Oration, pronounced by Mr. Oliver Fuller, introductory to the Examination of Mr. Silas Phelps, who was afterward admitted to Practice, and made a Member of the Corporation. And as most of the Members of the Corporation take the *Connecticut Courant*, it is their special Desire and Request, that the Printer thereof publish the before mentioned Dissertation and Oration, principally for their own Benefit: At the same time humbly hoping, that if they convey no Instruction, they may afford no disagreeable Amusement to any Gentlemen who read the *Courant*.

Postulat 1st.

That Mercury is the most ponderous of all Fluids.

2d That Mercury is the most Fluid of all Bodies.

3d. That Mercury is specifically heavier than our Blood in a ratio of 13 to 1.

4th That Mercury consists of Particles the most minute, pervading the Vascula Minima with Ease.

5th That the Particles of Mercury are perfect Spherules.

6th That with regard to Acids and Alcalies, Mercury is a perfect Neuter.

The Truth of these Propositions being already demonstrated by physical Authors that are common amongst us, I thought it needless for me to attempt it in this Place; and if they are admitted, are sufficient Data from which to account for all the Phenomena of the Operations of this celebrated Mineral on a living, human Body.

Mercury then, being applied to our Bodies, in any Manner, whereby it shall be capable of entering the Vessels, and mixing with our Fluids, will be presently returned with the venal Blood to the right Ventricle of the Heart: whence passing by the Arteria Pulmonalis and Vena Pulmonalis, will reach the left Ventricle, where it will be in the common

*A few emissions occur due to illegibility of the text.

Road of Circulation to all Parts of the Body. And here it may be necessary to premise, that the Circulation of the Blood depends on the muscular Force of the Heart and Arteries to propel forwards their contained Fluids, the Heart being the Primum Mobile: And this being granted, the Heart acts as any other mechanical Engine in thrusting out its contained Fluids, and according to the known Laws of Motion, the Celerity of all Bodies, when once put in Motion from any given Force, will be Coeteris Paribus, as their Densities are to their Surfaces.

Lemma 1st. by Postulat 3d. The Mercury in the left Ventricle of the Heart will acquire a Velocity 13 times greater than the Blood from the first Impetus given by the Heart.

Lem. 2d. That Mercury containing the most Matter under the least Surface, its Figure and Fluidity, all tend to make it persevere in a tight Line vastly longer than any Particles in our Fluids.

Lem. 3d. That the Particles of Mercury and of Blood, must loose continually of the Motion first impressed, and that it is a Ratio as their Surfaces are to their Densities and Vica Versa; that the Particles of Mercury must be relatively increasing in a Ratio of those of the Blood, as their Densities are to their Surfaces, all other Things being equal. But the Blood is a very tenacious Fluid, presently hardening, by and Cold, into a compact

mass. And by Postulat 2d. Mercury is the most Fluid of all Bodies, that it hath all the Advantage of the great Disproportion of Aptitude to Motion.

Lem. 4th. That the Mercurial Particles will exceed those of the Blood when they come to reach the least and smallest Vessels, both as to Force and Celerity, more than 100 to one. Whence the following Corollaries.

Corol. 1st. We may hence see how well calculated this Mercury is for destroying all Viscid Cohesions in our Blood, and whole Mass of Fluids, and even the component Globules thereof, viz. by its being moved forwards with a Force so vastly superior to that of the Blood; for - - - in a rectilinear motion of the Fluids the Mercury passing with so great Force and Swiftmess, dashes the Blood Globules to Pieces as a leaden Ball would a Row of Snow Balls, and in like Manner the Morbid Cohesions, but with much greater Advantage, as these latter incline to maintain their Positions, adhering to the Sides of the larger Vessels, and the Mouths of the Capillaries; so that each Ictus must be with much greater Force and Power than on a Body that is loose on all sides, in contact with nothing but a surrounding Fluid. But as all the Particles cannot pass long in right Line, by Reason of the conical

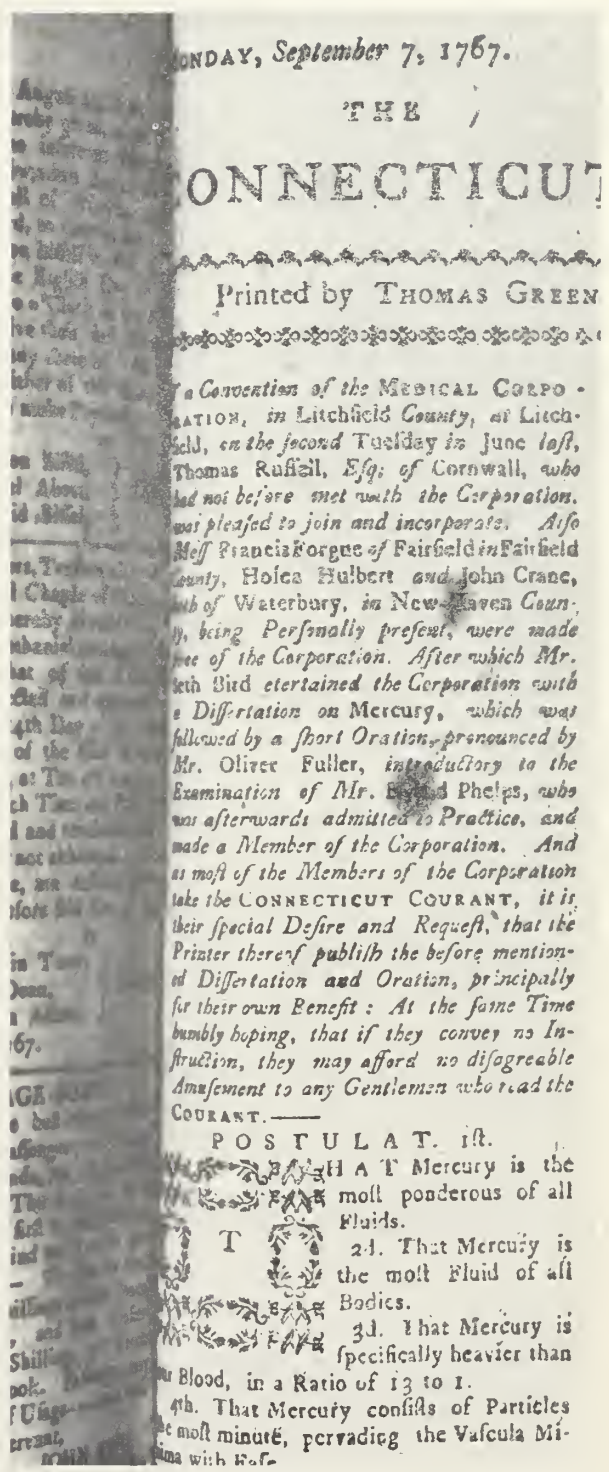


FIGURE 3
Photostatic copy of part of the report of the second meeting of The Medical Corporation, June, 1767, at which the first dissertaiton and the first oration were presented.

Form of the Vessels, there will consequently arise an intestine Motion in the Human, whereby the mercurial Particles will be variously agitated, and tossed from Side to Side of the Vessels, whereby the Vessels will also be urged to vibrate more briskly and smart, from all which the Fluids must be greatly comminuted, and from the increased Action of the Vessels, and repeated Percussions of those little mercurial globules. Whatever clogs the Vessels and hinders the free Circulation of the Fluids, must of Necessity in Time, be knocked to Pieces, rubbed off, and so far comminuted, as to be capable of being driven through the now Patulent Orifices of the Vessels and of Expulsion from the Body, when not fit for Circulation any longer in it.

Corol. 2d. Why it comes to be the most powerful in all chronick disorders, especially those depending on a pituitous Lentor? As to removing Obstructions in general, it hath already been accounted for in the last Paragraph. - - - But - - why, especially, in a pituitous Lentor? Because this is accumulated chiefly in the glandular Parts, Folicles and Cells which arise from the numerous Ends of the convoluted serous and lymphatic Vessels being the most sluggish Part of our Humor, separated and formed where the Circulation is the most languid. - - - But we have proved that Mercury acts with the greatest Force, and moves with the greatest Celerity relatively considered in those very Places last mentioned.

3d. Why it so plentifully promotes the fluid Secretions and Excretions? The Answer is easy, for the more our fluids are comminuted, and the oftener the particles to be secreted and excreted are brought to the Mouths of the secretory and excretory Vessels, by so much will their Discharge be increased. But that this is the Case, under the Operation of Mercury, we have proved in Corol. 1st.

4th. Why Mercury promotes a Salivation rather than any of the other Secretions? Here setting aside the antient Hypothesis of Volatility (making the Stomach, Gullet and Fauces serve as an Alembic) not only as vague and improbable, but notoriously false: For by certain chemical Experiments it appears, that Mercury doth not rise in Fume without a greater Degree of Heat than the Blood ever attains to in the Height of the most ardent Fever. It remains therefore, that we investigate the true Cause; and by the foregoing Doctrine it appears, that this hath the Advantage of all other Projectiks of persevering in a right Line; - - - but that the carotid Arteries (which supply the salival Glands with their Juices) do pass in the most direct Line from the Heart of any Vessels in the Body is beyond Dispute, consequently a much greater Quan-

tity of Mercury must pass these Vessels in Proportion to the Rest; and so rise to the salival Glands, for the Branches to these do not make greater Angles with their Trunks, than those to the other Parts of the Head; and we have before shown how greatly Mercury promotes the fluid Secretions; therefore, where the greatest Quantity is, there will be the greatest secretion: But the greatest Quantity is brought to those Glands.

5th. Why it destroys Acrimony of every Kind? And here it may be enquired, What Produces Acrimony in the Blood? And how many Kinds there are? And in answer to this I would observe that Acrimony may be produced various Ways; as by Stagnation and Rest, a spontaneous Dissolution and Putrefaction ensues, the salts are suffered to unite and form clusters unfit for an easy Circulation; and those may differ according to the Way of Living, and the various Substances made Use of in our Diet. Hence Cachexies of different Kinds, as Acid, Muriatic, Aromatic, etc. Again, by the increased Action of the Vessels in febrile Disorders, the animal salts may be increased and highly volatilized, and rendered very Acrimonious: But by Postulat 6th. Mercury being a neutral substance will not increase either acid or alkaline Acrimony—By Postulat 5th its Particles are perfect Spherules, or little Spheres, and not tending to unite very easily with any other Substance whatsoever (except the most strong and concentrated Acids, which can never exist in the human Body). The Force and Celerity with which the Mercury hath been demonstrated to move in our Vessels, in the foregoing Lemmas, will undoubtedly be sufficient to knock to Pieces those clusters of Salts, break off the Points of all those spiculated Particles, wherever they come in Contact, by which, In Time, they would be entirely destroyed.

6th. Why, after mercurial Courses, Persons are disposed to Acidities, especially of the Prima ? And perhaps several things may conduce hereto - - - As 1st. The spare vegetable Diet made Use of most commonly. 2d. The weak and exhausted State of the Bile. 3d. So great a Destruction of the red Globules. 4th. and lastly, at a Consequence of all the Rest, the Relaxation of all the Vessels, which is always the Case in acid.

7th. Why it answers best in robust Constitutions?

8th. Why in the Sanguinous, and Phlegmatic than Others?

I have chose to answer these two Heads under One, as the same Reasons serve for both: As mercurial Courses tack the Constitution, and weaken powerfully, the Reason is plain, why the Robust

will best bear it. The Sanguine are (generally speaking) those that have very elastic Fibres, a rich and dense Blood, a large Proportion of red Globules, which will therefore bear a Dissolution of the Blood Globules, and a Relaxation of the Vessels better than Others.

The Phlegmatic, whose Juices are naturally sluggish, are disposed to Corpulency, and will very well bear a Loss of Substance, and an Increase of Circulation, which they may be sure to meet with here.

9th. Why those whose Vessels are naturally slender and think, their Humors dilute, having a small Degree of Cohesion, cannot bear mercurial Courses, without manifest Damage to their Constitutions?

Here it is supposed that the condition of the Vessels and Fluids, is already below the healthful Standard, and the Error in both Cases, such as must inevitably be increased by Mercury: For a Body moving with that Force and Celerity as I have before demonstrated Mercury doth, cannot fail of dashing the now broken, dissolved Humors more and more to Pieces, and bringing them still into a greater Degree of Dissolution, and cause a constant and powerful abrasion from the Sides of the Vessels and prevent the Apposition of any new nutritious Particles, or at least but comparatively Few; whence Mirasmus, Dropsies etc. I would not be understood to suggest, that Mercury is never to be used in such Constitutions, but always with Caution; and if the good Ends to be obtained, are not much more than equal to the Evil we know must follow, it's evident it ought to be avoided.

10th. Why Mercury cannot be introduced into the Blood in any considerable Quantity with Safety, in the Height of inflammatory Fevers? For here a sanguine Plethora is supposed, the Vessels highly elastic, and a Heat greatly increased, and an increased Heat is essential to all Fevers, and more especially to this; but Heat rarifies all Bodies, and that in Proportion to their natural Rareness. But that the Blood is a very rare Body, will not be denied; and the more the Blood is rarified, the greater will be the secretion of animal Spirits, whence an Increase of the muscular Force of the Heart and Arteries - - - But the Heat of the Blood depends on the Action of the Vessels, therefore the greater the Action of the Vessels, the greater will be the Heat of the Blood, whence the Blood will be powerfully urged against the Sides of the Vessels, whose smallest Branches will be in eminent danger of bursting;—but if a Body 13 Times as solid as the Blood, and moving with a hundred Times the Force, be mixed with the Blood, and thrust therewith against the

Sides of the Vessels, the Danger of an Hemorrhage would be apparent. But this we have proved to be the case with Mercury.

11th. Why Mercury causes so great Disturbances on a sudden Constipation of the Pores by Cold? - - - Because the Mercury is hereby prevented from passing off by Perspiration, being greatly accumulated in those small Vessels, and retarded in its motion, by the coagulated Lymph (which by the Way, will be the Case, in Consequence of the Cold) and here a Body being confined in the Vessels, acting with such Force as we have before shewn this doth, must necessarily raise notable Tumults. As for Instance; in the loose Parts, Tumefaction in the Body, Pains, Inflammation, and finally in all a Putrefaction of the Humors, a Destruction of the Vessels, and an Extravasation of their contained Fluids, and a whole Train of the most dire Symptoms, too many to be here enumerated.

12th. Why so apt to take Cold in the Use of Mercury?

And this is principally owing to the Enlargement of the Pores, which is effected by so ponderous a Body passing swiftly and continually through them; which also undoubtedly abates of the muscular Force of the Sphinctors with which those Vessels are endowed, wearing their Sides thinner, and rendering them sensible to the Action of Acrimony, in which manner Cold is supposed to act upon them; yet not being able to contract and prevent the frigorific Particles entering, they suffer themselves to be wedged up by them, and the congealed Lymph.

13th. Why hard Meats are so detrimental in mercurial Courses?

This at best making a gross Chyle, laying a Load on the Vessels, which at this Time they are poorly able to bear, for nature, like other Servants, knows not how to serve two Masters; for while the whole muscular System is employed to withstand the violent Efforts of Mercury, it cannot be diverted in the Business of Digestion: Whence a crude Chyle, together with the morbid State of the Saliva, relaxing the Vessels, obstructing the circulation and Perspiration, and bringing the necessary ill Consequences which before have been enumerated to follow from these Particulars.

14th and lastly. Why Mercury is capable of answering many excellent Purposes, in the Hands of the skilful and prudent? And why so dangerous an Instrument in the Hands of the ignorant Pretender?

This needs not much explanation, as many of the good Purposes that may be answered, have already been pointed out, to which many more

might be added:—And if what is here delivered be true, it is apparent, that a Man destitute of the Knowledge of the Structure & Organization of the Human Body, the Circulation of the Blood, mechanical Powers and chemical Analysis of Medicine undertaking to prescribe such a Medicine as this, is like the Mad man, who calls Firebrands, Arrows and Death and saith, Am not I in Sport? For it is evident at first Blush that a Medicine that is capable of producing the greatest Changes and effecting the greatest Cures, must also be capable of doing the greatest Mischiefs, when misapplied. But we have before shewn, that Mercury is capable of producing the greatest Changes - - - and I would beg Leave here to subjoin a Declaration of the Immortal Boerhaave* "That Mercury alone cures one third Part of Diseases" - - - Therefore when this Medicine falls into the Hands of the above described Ignoramus's, it is altogether chance if they don't kill more than they cure therewith. But from the ill Effects of those Intruders may the good Lord deliver us!

The dissertation by Seth Bird was followed by Oliver Fuller's oration "introductory to the examination of Mr. Silas Phelps, who was afterward admitted to practice."

Generosissimi Auditors,

At the request of this worthy Congress give me Leave to interrupt your better Amusements by a concise unpolished and very superficial Discant upon the Medical Art and upon that which is of the greatest Importance to the Professors of it, Unanimity, Concord and Good Agreement.

Sed qui me Vertam quod Dicam, Ubi Incipere Nescio.

Should I attempt to range the Field of Nature - - thence to trace Diseases; the Task would be unequal, the Theme too sublime, far too sublime for my juvenile Capacity—or should I attempt a Treatise upon the Object of Physic, thereby to inculcate the Necessity, Usefulness and Dignity of the Art; this has already been done by abler Pens and is what Mankind have sufficiently experienced for many Ages, tho in its state

Therefore with the greatest Submission to your Candor and Generosity that I just touch upon natural Philosophy, the grand Basis of true medical Knowledge and which (in my humble Opinion) is the most necessary Acquirement, for a truly worthy and accomplished Aesculapion, as it contains in it the Science, or Knowledge of the Nature, Causes, Properties and Effects of Matter; the Laws by which

it is governed and regulated; the Attraction of Gravitation and Cohesion in particular; and that in Proportion to the cohesive Quality of the Particles is the Gravity, et Vice Versa. Hence arises the Solidity and Texture of the Same. Should we be a little more critical in our Enquiry and subdivide Matter into two Classes, that of Solids and Fluids we naturally derive an adequate Idea of the Circulation of the Fluids of the Human Body, as performed by the Gravity of the Fluid and Elasticity of the Fibre: And by taking but a flighty View of that Branch of natural Philosophy termed Pneumatology and consider the Density and Rarity of that homogeneous Fluid that composes our Atmosphere, a philosophic Reason readily occurs to the Mind of many of those surprising Changes that frequently and almost interchangeably take Place in this natural System, and upon the human Fabric in Particular the most delicate Part of the animal Creation - - - For by the Density of the Air both sensible and insensible Prespiration are wholly, or in Part obstructed; the most conducive to Health, the Elasticity of the Fibers increased, the Momentum of the Fluids augmented, and in Consequence a Lensor *sui generis*. By the Rarity, a universal Relaxation of the whole nervous system, an increased Prespiration, a languid Circulation and a Lensor *sui generis* ensues: By either of which Causes that Equilibrium between the Solids and the Fluids in which (philosophically speaking) true Health consists, is destroyed, and Diseases thence arise, according to the different State of the Solids and Fluids, in particular Habits previous thereto. Here Gentlemen, a large Field discloses to our View; many Causes arising from the different and immoderate Use of the Non Naturals might be enumerated; but, as I design Brevity, I beg Leave to wave them; only keeping this in View, that the Properties and different Qualities of the Particles of Matter and their Effects upon each other are a sure Clue to guide us in the Footsteps of Nature, by which we may not only be led into the Knowledge of Diseases by the Symptoms, but into the *Methodus Medendi* as comprehended both in the Galenical and Chemical Methods, consisting of Medicines, not only of the vegetable, but of the animal and mineral Kingdoms, suited to almost infinite Purposes in the healing Art.

And Gentlemen, since you have pleased to confer so great an Honor upon me (who am but a Youth) as to admit me as a Member of this medical Body; indulge me the Freedom to address you as Brethren. Since many ages are elapsed, the best methods improved to bring this art to its present Perfection, what is of greater Moment and Importance to Mankind than that we vigorously pursue the perfect Method? That Friendship, Harmony and good

*Vide Boerhaave's Institutes

Agreement subsist among us; that we are constant in our attendance upon every convention; that we ever act upon the highest and strictest Principles of Honor, Truth and Fidelity towards each other, and that we exert every Faculty for the Improvement of each other which are true Indices of a generous and noble Principle. Let us banish from our Breathe those low-lived acts and contracted Notions of Nostrums and Arcanas, the very Support of Ignorance and Empiricism, by which Thousands have been (as it were) butchered and are now blended with the common Dust! - - - The Growth of Physic and of this Society in Particular, depends upon the conduct of each individual Member. The Excellency of this Method, is very conspicuous in that lively and very instructive Dissertation just pronounced, and still further appears in the Method of examining Candidates for the Practise of Physic and Surgery. Should there be any present, I beg them to step forth - - -

Sir

I bid you heartily welcome, trusting you are not altogether insensible how important the Business, how arduous the Task, you now are about to assume for future Action in Life. Permit me to tell you, you have (as it were) tasted the Sweets, and now are entering a Scene of Trouble, complicated Perplexities and Fatigue where you'll daily be exposed to the licentious Wrongs of Judgments rash and Scourge of Slanderous Tongues. And should you (after a strict enquiry into your Knowledge of Philosophy, the Theory and Practice of Physic and Surgery) be admitted this Society, don't flatter yourself the Work is accomplished, but let me earnestly recommend as intense Application to Books every leisure Moment; a free converse with Men of Letters, by which that Fund of Knowledge will be increased, the Prospect grow more extensive, this infant Society nourished; 'til advancing slowly, by small improvements, she arrive to full maturity.

Gentlemen Spectators

I rely upon your Goodness and Generosity for Pardon in my Address, in just reminding you of your Obligation in this Respect. You can't but be sensible how great the Ignorance in the healing Art and the Growth of it this present Day, which calls for some Method to prevent the same. Then, how great the necessity of the Inhabitants of America, Connecticut, this County in particular, in its infant State, that some Way or other it should be suppress'd! Many Expedients, you are sensible, have been attempted, but proved abortive; the present is hoped and wished Success. And as you value and esteem Health, and the Growth of Physic (the greatest Blessings to Mankind) neglect the Imposter,

the Empiric and the false Pretender, and every One that slights so laudable a Method; his Practise bespeaks Ignorance, or a low, contracted Principle, and declares him an Enemy to himself and all Mankind. Neglect, did I say? I recall the Expression, as there are undoubtedly a Number of respectable Physicians within the Limits of this County, who have not (as yet) entered this Medical Corporation: Far be it from me to cast any the least Contempt or Reproach upon worthy Gentlemen of the Faculty; I mean to include those only who openly declare their Distaste to so glorious a Scheme (if I may be allowed the Expression) and who are known (by a Series of Instances) to be trifling with Men's Lives, only for the Sake of the Title of Doctor, and thereby to gain a small, tho' a very undeserved subsistence; whereby Gentlemen of Merit have been and are still brought in the greatest Contempt and Disrepute. View but the Man (whether obtained by a liberal Education or a closer Application of his more sprightly Genius) that has spent his Youth, his Fortune in Nature's Lap, and has (as it were) rifled her of all her charms, and gay attire, for the Good of Mankind - - - I say, view his character, as a Gentleman, Scholar and Physician: Him improve, not only for your own Safety and Advantage, but for the Encouragement of true medical Knowledge and for the Discouraging and eradicating those base-born Sons of Infamy. And let Us join Hand and Heart, in a Cause so Glorious; live and act open, generous and free.

Bird's dissertation appears to have been inspired by Newton's Laws of Physics, and the immortal Boerhaave. It surely should have made both the public and the ignorant pretenders in the healing art wary about the use of mercury. Perhaps the author had in mind the remarks made some years earlier by the distinguished Cotton Mather who, in his essay on Common Maladies of Mankind, said, "Mercury we know thee; but we are afraid thou wilt kill us too, if we employ thee to kill them that kill us."

Dr. Seth Bird,* the author of the Society's first dissertation, was born in Bethlehem, formerly a part of the town of Litchfield, in 1733, and, except for his apprenticeship under the brilliant James Hurlburt, he spent his life in active practice in Litchfield. His first wife, Sarah, died when 29 years of age in 1766, and his second wife, Hannah, in 1803, about two years prior to his own death. Dr. Buel³⁰ of

*This is the first paper presented in the Connecticut colony and, as such, is of historic interest.

Litchfield referred to him as a remarkable man with prodigious vigor of mind, having great ability and originality. Bird was fortunate in his opportunity to study under James Hurlburt who was known for his knowledge, sound teaching and remarkable memory. Thoms³¹ says of him that, "He was a Latin, Greek and Hebrew scholar, and called by Woodward the greatest genius in the ranks of the medical profession in the last century." In reprimanding one of his younger colleagues for being late, Bird²⁷ is quoted as saying, "In over forty years of practice I have never made a physician wait a moment." Considering the difficulties of climate and transportation this was a remarkable achievement!

Bird apparently took an active part in the medical society and in the medical affairs of the colony. He was chosen by the General Assembly as one of eighteen physicians to pass upon the qualifications of physicians who might volunteer for service in the Continental Army. Of these eighteen men, three were members of the Society; Seth Bird, Reubin Smith and Elisha Sill. The General Assembly had resolved that any three of the committee were authorized to examine such physicians as might offer their services as surgeons or surgeon's mates, and after full evidence of proper and sufficient qualifications, to give certificates accordingly. Bird lived a full and productive career, having trained a number of physicians, among them Lemuel Hopkins, who considered him the greatest physician of his acquaintance. Thus Bird assumed his fair share of the responsibilities of the community. He was buried in the cemetery in Morris, formerly a part of Litchfield. On his tombstone is found the following:

This is the grave of
Seth Bird Physician
who died on the first of October
One Thousand Eight Hundred &
Five, in his seventy-third year.
Those whose pains have by his
skill and care been alleviated
or whose lives have been
protracted; will give a more sincere
eulogium than can marble.
Posuit Filius

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(Continued in next issue)

A STUDY OF EMBRYOMAS AND RETROPERITONEAL NEUROBLASTOMAS

JACOB MAINZER, M.D., *Detroit, Michigan*, and DONALD P. SHEDD, M.D., *New Haven*

THE two common abdominal neoplasms of childhood, the Wilms' embryoma and the retroperitoneal neuroblastoma, have long been regarded as having a uniformly grave prognosis. Recent studies and reviews^{1,2,3} reveal that not only are there very worthwhile types of palliative therapy available at present, but that surprisingly high cure rates have been obtained in the treatment of these two tumors, which constitute a considerable percentage of all pediatric malignancies. This has been estimated to be about 35 per cent.

In the present study all the cases of embryomas and retroperitoneal neuroblastomas seen at the New Haven Hospital during the period 1941 to 1955 have been reviewed. There were twelve embryomas and eleven neuroblastomas.

PRESENTATION OF DATA

SURVIVAL RATE

Among the total 23 cases reviewed, five patients have survived asymptotically for periods of from four to thirteen years after treatment. There have been 16 deaths. Two cases have been treated within the past two years, and though asymptomatic, are considered to have been followed for an inadequate period of time, and will not be included in data regarding survival. The overall survival rate, therefore, is 24 per cent (5 survivals/21 patients). Among the 11 embryoma patients there were three survivors and eight deaths, and the survival rate following treatment was therefore 27 per cent. Among the neuroblastoma patients there were two survivors and eight deaths and the survival rate here was 20 per cent.

AGE

The average age at the time of hospitalization of the survivors and nonsurvivors is noted in Table I. Only one patient was older than five years of age at the time of hospitalization. This patient was 12 years old.

Dr. Mainzer. *Intern, Detroit Receiving Hospital, Detroit, Michigan*

Dr. Shedd. *Assistant Professor, Department of Surgery, Yale University School of Medicine, New Haven, Connecticut*

SUMMARY

Data concerning 23 children with malignant abdominal tumors (12 embryomas and 11 neuroblastomas) were analysed. Five cures were noted among 21 adequately followed cases, the survival rate being 24 per cent. The survival rate in the embryoma patients was 27 per cent; that in the neuroblastoma group, 20 per cent. These results are comparable with those reported in other series.

A younger average age was noted among survivors with both types of tumors when compared with fatal cases, suggesting that the younger the patient, the better the prognosis.

Analysis of initial symptoms showed that embryoma patients most often present with a palpable mass and neuroblastoma patients with either an abdominal mass or a nonspecific gastrointestinal disturbance. Only one patient's initial symptom was due to a metastasis. The presence of an abdominal mass in a child, especially under five years of age, should impel the physician to carry out immediate diagnostic study. Only in this manner can the chances for survival be improved.

All three of our survivors with embryomas had nephrectomy. No embryoma patient was cured by irradiation therapy alone. One of the two neuroblastoma survivors received surgical treatment, the other received only irradiation. Combined surgical and irradiation therapy prolonged the average survival of those who succumbed with either tumor.

The treatment of choice is early surgical intervention with postoperative irradiation.

TABLE I
AGE AT THE TIME OF HOSPITALIZATION

AVERAGE AGE OF SURVIVORS			AVERAGE AGE OF KNOWN NONSURVIVORS		
TOTAL	NEUROBL.	EMBRYOMAS	TOTAL	NEUROBL.	EMBRYOMAS
5 CASES	2 CASES	3 CASES	16 CASES	8 CASES	8 CASES
15 mo.	4 mo.	23 mo.	42 mo.	27 mo.	57 mo.

SYMPTOMATOLOGY

The earliest symptoms as noted in each case are tabulated in Table II.

TABLE II
INITIAL SYMPTOMS

NEUROBLASTOMAS		EMBRYOMAS	
CASES	SYMPTOMS	CASES	SYMPTOMS
4	mass palpated	8	mass palpated
2	abdominal pain	1	abd. pain and vomiting
2	abdominal distention	1	abdominal pain
1	megacolon	1	vomiting
1	left eye ext. rectus paralysis (metastasis)	1	hematuria
1	none—tumor was an incidental autopsy finding		

From the data it appears that embryomas more often than neuroblastomas make their presence known by the finding (often accidental) of a palpable mass. Neuroblastomas seemed to present about equally with either gastrointestinal symptoms or with a palpable mass. Upon admission physical examination, however, all but four of the 23 patients presented a palpable mass.

TREATMENT

Among eight embryoma patients who were treated by nephrectomy there were three survivors. Two of these three survivors also received irradiation therapy. No embryoma patient was cured by irradiation alone. Of the two neuroblastoma survivors, one patient received only irradiation therapy and the other was treated by surgical removal of the mass without other treatment.

The average survival time, that is the time from the first symptom to death, of all fatal neuroblastoma cases was nine months, while among embryoma cases who died, the average survival time was only four and one-half months. In these nonsurvivors surgical removal of the primary tumor resulted in a prolongation of life of the patient beyond these average times, although the patient eventually succumbed.

DISCUSSION

The survival rates noted above seem to indicate clearly that these tumors are potentially curable, and these data compare favorably to that from other investigators, as shown in Table III for each type of tumor. It appears from the data that the survival rates for patients with embryomas are somewhat better than for those with neuroblastomas.

TABLE III
NEUROBLASTOMAS

SURVEY	TOTAL SURVIVAL		
	CURES	CASES	PER CENT
Present study, New Haven Hospital.....	2	10	20
Gross, ¹ Boston, 1921-1940.....	11	57	19
Gross, ¹ Boston, 1940-1947.....	11	38	29
Phillips, ⁴ New York.....	10	58	17
Koop, ⁵ Philadelphia.....	15	41	36
Beck, ² review of literature, 1951.....	47	475	10

EMBRYOMAS

SURVEY	TOTAL SURVIVAL		
	CURES	CASES	PER CENT
Present study, New Haven Hospital.....	3	11	27
Gross, ¹ Boston, 1931-1939.....	10	31	32
Gross, ¹ Boston, 1940-1947.....	18	38	47
Weisel, ⁶ Rochester, Minn.	7	44	16
Silver, ⁷ San Francisco.....	10	18	56
Dean, ⁸ New York.....	5	20	25
Harvey, ³ review of literature, 1950.....	124	716	17.3

The finding of a younger average age (see Table I) among survivors with respect to both types of tumors correlates well with Gross's¹ results who found an 80 per cent survival among embryoma patients under 12 months of age, as opposed to a 43 per cent survival rate among those above this age. In the neuroblastoma patients the younger group had a 45 per cent survival rate, whereas that among those older than 24 months was 11 per cent.

From the data presented in Table II, it is clear that the finding of an abdominal mass is the most common initial symptom, and that a symptom referable to the gastrointestinal tract is the second most common complaint. Further, from the data it appears Wilms' embryomas will more often than neuroblastomas present as an abdominal mass. This correlates with the finding that neuroblastomas are generally somewhat smaller than embryomas. The higher mortality rate among neuroblastoma patients may be related to this size differential, which decreases chances of early and accidental diagnosis,



FIGURE 1

Preoperative photograph of a 3 month old female infant with a Wilms' tumor on the right side; the mass is visible

as well as to the rather nonspecific nature of the GI symptoms which are commoner as initial symptoms in neuroblastoma patients.

It is difficult to assess the role of preoperative and postoperative irradiation therapy as an adjunct to surgical removal of the tumor. Gross¹ states that postoperative irradiation therapy has increased the survival rate in embryoma patients by 15 per cent. The number of patients in the present series studied is insufficient to permit any conclusion. It is, however, evident that patients receiving irradiation therapy without surgical removal of the lesion did considerably better than those untreated. Apparently one patient was cured of neuroblastoma by irradiation therapy alone. There is no clearcut evidence for the use of preoperative irradiation, and it is believed that it may do harm in allowing time for metastasis to occur. Dean⁸ treated 20 cases of Wilms' embryoma exclusively with irradiation and had a 25 per cent five year survival rate. Uhlmann⁹ similarly reported a series of 17 patients with neuroblastomas treated exclusively by irradiation and obtained a survival rate of 35 per cent (6 survivors). Koop,⁵ however, emphasizes the value of and the need for early surgical intervention in the cure of neuroblastomas. There is little question now as to the validity of this recommendation.

Koop⁵ emphasized that metastases to the liver in neuroblastoma patients were not invariably fatal. He

described three deaths in seven such patients. This is supported by one neuroblastoma survival in the present study, in whom liver biopsy showed metastases and who was successfully treated by irradiation alone.



FIGURE 2

Same patient as shown in Figure 1. Postoperative photograph showing the relative size of the excised tumor to the infant

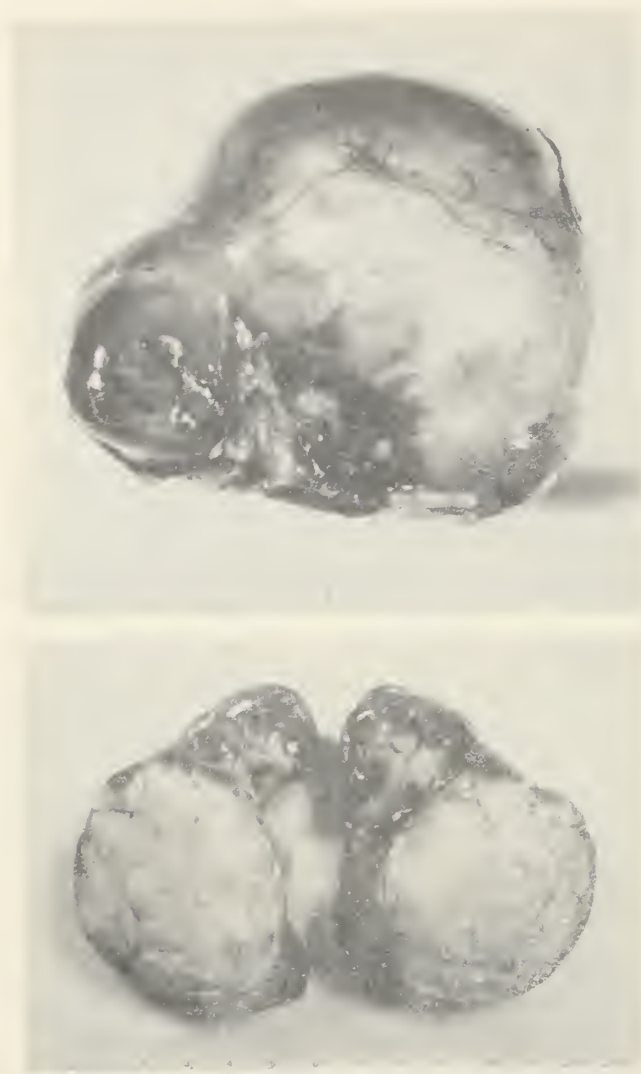


FIGURE 3

Operative specimen from a patient with an embryoma who has been followed for over thirteen years and remains asymptomatic. The tumor mass fills the entire lower pole of the kidney

In summary of treatment methods it can be said that there have been cures after either x-ray or surgical intervention, alone or together, in the neuroblastoma group, and cures by surgery with or without irradiation in the embryomas. It seems that the best results have been obtained with a combination of the two methods. Chemotherapeutic attacks on these tumors (especially neuroblastomas) have been attempted in the past, but more recently interest has been focused on the folic acid antagonists by Farber¹⁰ and on massive doses of B₁₂ (noted by Koop⁵). Chemotherapy is hopefully looked to as a future curative therapy.

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CLINICAL EXPERIENCE WITH AN ORAL, RAPIDLY-ACTING, THEOPHYLLINE PREPARATION

FREDERICK KESSLER, M.D., *New Haven*

WHEN an asthma attack can be checked promptly, not only is the patient spared much suffering, but further changes in the tissues of the bronchial wall may be prevented. In the long run, the amount of medication needed for prevention of attacks is diminished in proportion to the promptness and ease with which relief is provided by the remedy available to the patient.

Parenteral injections of epinephrine or, in epinephrine-fastness, of aminophylline, are the two most reliable means available to rapidly terminate an attack. What a boon it would be in the management of asthma, if either of these drugs were available in a form equally effective when given by mouth, and could be taken without discomfort by the patient when needed. The daily administration of the central nervous system stimulating sympathomimetics, sedatives, suppositories, and steroids could thus be reduced to a minimum, and in many cases might not be required at all.

But epinephrine is inactive orally and aminophylline is virtually so for relief of an acute asthmatic attack. Intravenously, aminophylline is commonly given in a 500 mg. dose. Gastric distress precludes the administration of doses by the oral route which are effective for the relief of an attack. The largest dose usually recommended is 200 mg., given either as aminophylline or as the choline or other salt of theophylline (in theophylline-equivalent dosage). The efficacy of these relatively small doses is further reduced by their relatively slow absorption. Enteric coated, certainly, and aluminum hydroxide preparations of aminophylline, probably, are even more slowly absorbed.

Allergy, of course, is the focal point in the management of the patient with bronchial asthma. But psychogenic factors often impinge on the success of the control of the allergic condition. Psychic trauma in childhood may be of etiologic significance, but current emotional upsets may be more pertinent to the success of management. Some of the latter

The Author. *Assistant Junior Attending in Allergy, St. Raphael's Hospital, New Haven, Connecticut*

SUMMARY

Seventeen patients were treated with Elixophyllin. Thirteen were subject to frequent, acute attacks. Eleven secured prompt, and in some cases, dramatic relief of their attacks. Patients who were at first relieved in 15 to 20 minutes, responded in a much shorter time in subsequent attacks, and attacks became less frequent and less severe. Wheezing, dyspnea and retrosternal tightness were largely or completely relieved by small doses adjusted to the patient's needs. The need for auxiliary aids steadily diminished and was eliminated in most cases. Five patients taking hormones were able to discontinue their use.

Two patients were not relieved of acute attacks. One was intolerant to all medication, and the other was a severe case with extensive complications, who had to be frequently hospitalized for status asthmaticus.

The remaining four patients were free from attacks while taking Elixophyllin. Two had been subject to mild attacks; they had no attacks or wheezing while taking Elixophyllin. One of them gained 20 needed pounds in three months. A third patient whose complaint was wheezing was entirely relieved of symptoms. The fourth, a four year old boy, was subject to three or four daily attacks of retrosternal tightness which were relieved by 10 cc. doses of Elixophyllin. The attacks diminished in number and the patient now requires only an evening dose. An accompanying eczema improved.

Elixophyllin was used also as an emergency treatment for patients suffering from attacks or from retrosternal tightness on office visits; and also in one patient who exhibited a mild anaphylactic reaction to a hyposensitization injection. Relief was prompt in every case.

episodes may be beyond prevention by the physician, but is it possible that our remedies at times commit psychic injury or lessen the ability to adjust to psychic assault?

The "jitteriness," rapid heart beat, and other side-effects produced by epinephrine, ephedrine and other sympathomimetic amines are necessary evils and tolerated only in order to obtain relief of asthma; but these effects conceivably may mitigate against the success of our general management. An increasing need of the drug or an increase in severity of symptoms paradoxically, may be an indication of the disturbance the patient feels in response to the remedy. Similarly, the inconvenience of insertion of a rectal suppository; or the possible embarrassment with the use of a personal device (inhalator) in public; or the gastric discomfort or lethargy caused by a drug all may seem trivial complaints compared with the asthmatic symptoms. But in the sensitive patient may not these "trivia" aggravate the psychogenic element of his asthma?

These questions are posed here because quite the opposite was observed in many of patients who experienced no side-effects and who secured fast relief from their attacks with an oral, alcoholic solution of theophylline (Elixophyllin).*

Each 15 cc. of this preparation contains 80 mg. of theophylline—equivalent to 100 mg. of aminophylline—and 3 cc. of ethyl alcohol. Doses of 60 to 90 cc. were administered for relief of acute attacks in adults and comparable doses, based on age, in children. This is the equivalent of 400 mg. to 600 mg. of aminophylline. With the exception of one patient who reacted similarly to other drugs including placebos, no gastric discomfort or other side effects occurred.

Relief was obtained in all cases except the "placebo reactor," and in status asthmaticus and in one patient with extensive complications. After obtaining repeated relief of attacks patients made a noticeable change for the better: subsequent to initial use, relief was secured more quickly from the same dosage; attacks became less frequent and less severe; wheezing and retrosternal tightness were relieved by small, regular doses; and many experienced a noticeable improvement in general health and morale. Two gained needed weight.

The promptness with which relief of attacks is secured is important in itself. But, in part, the results

may reflect additional benefits which accrue thereby; the knowledge that fast relief is available; that the remedy is simple and easy to use; and that no side effects attend its use—all tend to comfort the patient and to foster his emotional stability. Previously, some of these patients had experienced an increasing need for drugs and several had been taking hormones for relief. When Elixophyllin was started, the drugs formerly taken were decreased and, in most cases, finally omitted. Five patients taking hormones were thus freed from their need.

CASE REPORTS

The case reports are presented in tabulated form. Arrangement is by age of the patient. Case 6 is a clinic patient. The others are from private practice. All had been referred after previous treatment elsewhere and the remedies indicated under "Prior Treatment" were, for the most part, instituted by others. All of those taking hormones were placed on this therapy before referral to me. I concur heartily in the general consensus of opinion among allergists that these potent drugs should be reserved as a last resort for patients intractable to other methods of control.^{1,2}

All patients were on an orthodox allergy-management regimen. Hyposensitizing treatment was employed in all except Case 17.

Elixophyllin in individually adjusted doses prevents dyspnea and wheezing. These benefits are not always secured immediately. This was carefully explained to each patient and the medication formerly given was continued at first at a lower dose level. These drugs could usually be discontinued entirely when the Elixophyllin requirement had been determined with the patient's cooperation.

The patients ranged in age from four to 69 years; in duration of asthma from one month to 32 years; in severity of symptoms, from mild to extremely severe. They were observed while on Elixophyllin for a period of four weeks to four months.

DISCUSSION

The limited usefulness of the usual doses of oral theophylline products for the relief of asthma have been frequently noted. On the other hand, parenteral administration of aminophylline is a notably efficient procedure for providing relief.

With Elixophyllin this limitation of oral theophylline therapy is sufficiently lifted to warrant the statement that it adds a new dimension of usefulness to a time-tested drug. Doses two to three times as

*Sherman Laboratories, Detroit, Michigan

large as customary oral doses were well tolerated and rapidly absorbed as clinically evidenced by rapid relief of attacks. Absorption is most rapid on an empty stomach.

The relief provided is of longer duration than that from epinephrine and, unlike epinephrine, relief is not accompanied by disturbing side effects. Large amounts of sputum were raised with the cessation of the attack.

The most dramatic results were seen in milder forms of asthma of short duration, and in younger people. Relief was almost instantaneous in some of these cases. More severe attacks requiring a longer period (20 to 30 minutes) for relief from initial doses, often responded more rapidly in later attacks (5 to 15 minutes).

Less dramatic but perhaps an equally gratifying response was observed with relatively small doses in debilitated older people with chronic bronchitis and emphysema, but not troubled by severe attacks of asthma. This was especially notable with Case 14. An improvement in general circulation and in pulmonary circulation may account for this. Theophylline dilates peripheral blood vessels and increases cardiac output. Alcohol also dilates peripheral vessels. The net result is a more efficient circulation.³

Three patients were subject to recurrences of status asthmaticus. Elixophyllin was ineffective in relieving their status asthmaticus. Dehydration was a prominent feature and required rehydration by intravenous fluid. However, one of these patients (Case 7) who had three status attacks in the four months preceding Elixophyllin therapy had had no recurrences in the three months while on this preparation. In fact, in the last thirty days she had no asthmatic attacks at all and no wheezing. The second patient (Case 4) has had less recurrences of status asthmaticus; is relieved of average attacks in 15 to 20 minutes by 75 cc. of Elixophyllin; and 15 cc. t.i.d. relieves average wheezing and lessens the number of asthmatic attacks.

The third patient (Case 11) was not relieved of severe attacks or of harder wheezing even with doses of 75 cc. Her less severe attacks responded slowly to this dose. This patient's asthma of 20 years duration was complicated by post-nasal dripping, sino-bronchial disease and emphysema. In asthma of long duration and/or of great severity, pathological changes in the tissues may be the cause of poor response to all kinds of therapies. inspissated mucous plugs, chronic swelling of the bronchial wall, swell-

ing of the collagen fibrils, thickening of the basement membrane and cellular infiltration of the mucosa may be prominent features relatively unresponsive to medication.

Potassium iodide had been administered to many of these patients in the past. In some cases presented here it may have been a useful additional therapy, but was not employed in this study in order to obtain a clearer evaluation of Elixophyllin. If desired it may be incorporated in the Elixophyllin prescription, if the patient is not subject to acute attacks. It would be best administered separately if the Elixophyllin may be required in larger doses for relief of an acute attack. Another reason for prescribing separately is the dose adjustment of K.I. often needed, because of the poor gastric tolerance of some patients to potassium iodide.

For like reasons, in very severe cases in which it may augment the therapy, ephedrine would be best prescribed separately. In that way the dose of ephedrine (and barbital) may be reduced to a minimum. Most of my patients were able to discontinue the use of ephedrine and other drugs and showed greatest clinical improvement when controlled with Elixophyllin alone. One patient's severe attacks are relieved by 0.3 cc. of epinephrine (self administered) in addition to Elixophyllin. Previously these attacks had required parenteral aminophylline (professionally administered) plus 0.5 cc. of epinephrine.

To avoid gastric effects, aminophylline is frequently administered in suppositories, particularly in children. Because absorption is usually slow, the doses have been quite large for children (250 to 500 mg.). But absorption from suppositories varies greatly and occasionally, as when the mucosa is irritated, absorption is rapid. Poisoning and fatalities have occurred thereby.⁴ In my experience theophylline administered as Elixophyllin was rapidly absorbed, particularly when the stomach was empty. Hence, relatively small doses can be depended upon to provide relief. The four year old patient obtained relief in 15 minutes with a dose containing only 53 mg. of theophylline. This is one fourth the dose usually employed in suppositories for children of this age. The nine year old responded to 80 mg. and the fourteen year old to 160 mg. at first, and to 80 mg. doses later.

The alcohol in Elixophyllin may serve an important role beyond that of facilitating absorption of the theophyllin. Hot whiskey is a remedy for asthma mentioned in the 1901 edition of Osler's Practice of

TABULATED CASE REPORTS

HISTORY			ELIXOPHYLLIN THERAPY				
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
CASE SEX AGE	DURATION OF ASTHMA	CLINICAL ASSESSMENT OF CONDITION	PRIOR MEDICATION AND COMMENTS	IN ACUTE ATTACKS	RESULTS AND COMMENTS	DAILY USE FOR: PREVENTION OF ATTACKS; OR FOR RELIEF OF ATTACKS; OR FOR WHEEZING AND RETROSTERNAL TIGHTNESS	RESULTS AND COMMENTS
1 (DK) M 4 years	1 month	Pollen allergy; "tight chest;" eczema.	Syr. Ephedrine and Syr. Chlor- trimeton, aa equal parts. No relief.		Not subject to acute asthmatic attacks.	10 cc. in 15 minutes lasting 4 to 6 hours. At first required 3 to 4 doses daily—now once a day, after sunset. Fezema improved.	Relief of retrosternal tightness
2 (PG) F 9 years	2 years	Bacterial, dust, and pollen asthma; subject to moderate- ly severe attacks.	Tedral and antihistamine help- ful, but caused rapid heart beat and nausea. Prednisolone.	15 cc. p.r.n.	Almost immediate relief, lasting for hours. Used one to three doses daily. Now only occa- sionally at night.	15 cc. Prednisolone discontinued. At- tacks keep lessening in number.	
3 (MT) F 14 years	4 years	Bacterial and pollen asthma. K.I.; Subject to severe attacks.	Tedral suppositories; then epinephrine subcutaneously. After becoming "epinephrine fast" prednisolone. Side-effects apparent from hormone ther- apy.	15 cc. to 30 cc. p.r.n.	Relief in 10 to 20 minutes last- ing for several hours.	15 cc. Uses one to four doses daily. Prednisolone discontinued.	
4 (RF) M 21 years	19 years	Bacterial, dust, pollen, and psychogenic asthma. Attacks frequent and very severe; often developing into status asthmaticus.	Oral: ephedrine, theophylline, and barbitol tablets; K.I. Epine- phrine by inhalation and sub- cutaneous routes. Prednisolone. Aminophylline I.V. for status asthmaticus.	60 cc. to 75 cc.	Relieves usual attacks in 15 to 20 minutes. Does not relieve status asthmaticus.	15 cc. Relieved wheezing and retro- sternal tightness. Reduced at- tacks and number of recur- rences of status asthmaticus. t.i.d. Permitted discontinuance of prednisolone after two months of Elixophyllin therapy.	
5 (EL) M 27 years	7 years	Pollen, dust, and bacterial asthma.	Gamut of therapy. Tedral had to be taken often in spite of many side-effects suffered. Prednisolone.	60 cc.	Relieves every attack. At first, in 15 to 20 minutes; now (6/22/ 56) almost immediately.	15 cc. Very few attacks since starting on Elixophyllin. Tedral and prednisolone discontinued. Feels greatly improved.	
6 (GI) M 31 years	2 years	Bacterial and pollen asthma. Subject to frequent moderate and severe attacks. Chronic bronchitis.	K.I. Usual attacks: epinephrine subcutaneous. Severe attacks: aminophylline, I.V. plus epine- phrine 0.5 cc. Prednisolone.	60 cc. to 75 cc.	Relieved usual attacks in 20 minutes at first; now (6/22/56) in 5 to 10 minutes. Severe at- tacks relieved by additional epinephrine 0.3 cc. subcutane- ously.	45 cc. Wheezing and retrosternal tightness relieved. Wheezing now only on arising and re- lieved by 45 cc. Prednisolone entirely discontinued two months after starting Elixo- phyllin. Greatly improved.	

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
CASE SEX AGE	DURATION OF ASTHMA	CLINICAL ASSESSMENT OF CONDITION	PRIOR MEDICATION AND COMMENTS	IN ACUTE ATTACKS	RESULTS AND COMMENTS	DAILY USE FOR: PREVENTION OF ATTACKS; OR FOR RELIEF OF ATTACKS; OR FOR WHEEZING AND RETROSTERNAL TIGHTNESS	RESULTS AND COMMENTS
7 (FH) F 38 years	6 months	Very severe bacterial asthma. Occasionally psychogenic. Three bouts of status asthmaticus in 4 months preceding Elixophyllin.	Gamut of therapy, including K.I.; epinephrine subcutaneous, aminophylline I.V.	60 cc. to 75 cc.	First tried in status—without relief. Relieved average attacks in 10 to 15 minutes.	15 cc. t.i.d.	Relieved wheezing. No occurrences of status since starting on Elixophyllin. Has had no attacks at all and no wheezing in past 30 days. Patient extremely grateful.
8 (JL) M 40 years	32 years	Pollen, dust, bacterial and fumes asthma. Two to three severe attacks weekly. Heavy smoker. Dyspnea on exertion. Chronic bronchitis. Emphysema.	Amesec (aminophylline epinephrine phenobarbital). A cough mixture (K.I.?) Very little relief. Complained of drowsiness.	90 cc.	Relieved in 30 minutes.	30 cc. t.i.d.	Same number (2 to 3) attacks first 3 weeks; none in 4th week. Now, after one month of therapy, has less wheezing, less dyspnea, has gained 8 pounds and able to work overtime. Impressive improvement in general health.
9 (MR) M 41 years	20 years	Bacterial and pollen asthma. One or two moderate or mild attacks weekly. Chronic bronchitis.	K.I.; Tedral p.r.n.	45 cc. to 60 cc.	Relief of every attack within 20 minutes.	15 cc. b.i.d.	Relieves wheezing.
10 (MM) F 45 years	4 years	Bacterial, dust and psychogenic asthma. One to two mild attacks weekly. Mild chronic bronchitis.		60 cc.	Almost immediate relief.	15 cc. 2 or 3 times daily	Relieves wheezing and prevents attacks.
11 (AM) F 45 years	20 years	Bacterial, dust and pollen asthma. Sino-bronchial disease. Post-nasal drip. Emphysema. Subject to severe attacks. Four occurrences of status asthmaticus past 12 months.	K.I. etc. Uses M.S.A. positive pressure machine three or four times daily at home. Very little relief obtained for severe attacks. Hospitalized for status; relieved by I.V. ACTH, aminophylline, etc.	60 cc. to 75 cc.	Relieves milder attacks in 30 minutes. No relief for more severe attacks or status asthmaticus.	15 cc. q.i.d.	Gives slight relief of wheezing.
12 (EM) M 54 years	20 years	Pollen, dust, bacterial and psychogenic asthma. Two to three severe attacks weekly. Emphysema.	Tedral and epinephrine inhalations afforded some relief, but made "shaky and nervous." Still had dyspnea on exertion.	90 cc.	Relief of severe attacks in 30 minutes.	30 cc. t.i.d.	Dyspnea greatly relieved. Attacks reduced to average of one every two weeks. Tedral and epinephrine discontinued.
13 (RE) F 55 years	3 years	Attacks of wheezing for 3 years. Pollen, dust, bacterial and psychogenic asthma.	K.I.; telidine; and pyribenzamine. Slight relief.			15 cc. t.i.d.	Wheezing stopped. (One-half perazil tablet given at bedtime.)

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
CASE SEX AGE	DURATION OF ASTHMA	CLINICAL ASSESSMENT OF CONDITION	PRIOR MEDICATION AND COMMENTS	IN ACUTE ATTACKS	RESULTS AND COMMENTS	DAILY USE FOR: PREVENTION OF ATTACKS; OR FOR RELIEF OF ATTACKS; OR FOR WHEEZING AND RETROSTERNAL TIGHTNESS	RESULTS AND COMMENTS
14 (EG) F 59 years	5 years	Bacterial, dust, pollen and food asthma. Chronic bronchitis. Marked emphysema. Persistent wheezing. One to two moderate attacks weekly.	Aminophylline suppositories. Tedral tablets. Greatly distressed by both: "preferred wheezing to medication."		Has had no attacks since starting on Elixophyllin.	15 cc. No more wheezing. Able to walk and to work. No attacks in three months since taking Elixophyllin. General condition tremendously improved—has gained 20 lbs.	
15 (EF) F 58 years	25 years	Bacterial, dust, pollen and emotional asthma. Severe emphysema. Sino-bronchial disease. Status at times.	Intractable to all therapies. Intolerant to ACTH, prednisone and prednisolone.	60 cc.	Tried only once. No relief—quickly nauseated. Also nauseated by all other therapies prescribed, including prednisolone and placebos.		
16 (EB) M 61 years	5 years	Pollen, dust, bacterial and emotional asthma.	Suppositories, Tedral tablets, benadryl with ephedrine. Distressed by side-effects.	60 cc.	Promptly relieved.		
17 (MT) F 69 years	25 years	Intermittent asthma (dust) for 25 years. Persistent for past 2 years. Emphysema. Chronic bronchitis. One to two moderate to severe attacks daily.	K.I.; 8 to 10 Tedral tablets daily. Shaky, nervous, labored breathing.	75 cc.	Most attacks relieved in 20 to 30 minutes without additional medication.	30 cc. Much less dyspnea. Still takes one or two Tedral daily. Feels much better—free from "nervousness," and morale greatly improved.	

Medicine and in the 1952 edition of Beckman's Pharmacological Basis of Therapeutics. The latter describes also the successful use of ethyl alcohol in the treatment of status asthmaticus: 80 to 100 cc. of a five per cent solution in five per cent dextrose being given in the first ten minutes, and the balance of the infusion at the oxidation rate of alcohol.^{5,6}

The 75 cc. dose of Elixophyllin supplies 15 cc. of alcohol. This oral dose of the rapidly absorbed alcohol may supply alcohol blood levels comparable to that obtained with 4 to 5 cc. administered intravenously during the first ten minutes. The rehydration afforded by the infusion is, of course, of prime importance in the recovery of the patients with status asthmaticus.

As a relaxant in asthma, alcohol in small controlled doses has much to recommend it. An incipient attack provokes fear which may aggravate the attack. This psychogenic element is increasingly being recognized as a "trigger." Alcohol acts with the speed required in such situations and aids in relieving the peribronchial spasm. It is unmatched in this by any mood drug. Alcohol thus affords periodic relaxation to avoid trigger tensions resulting from exposure to irritants, or from psychogenic situations, or from strain and fatigue. The patient avoids continuous sedation and exposure to the barbiturates. Unlike the barbiturates, alcohol does not depress respiration. It is rapidly and completely oxidized. The dose is too small to cause any feeling of intoxication and its abuse in Elixophyllin need not be feared, as might be the case if an alcoholic beverage would be recommended. It is sold only on prescription. Far from being "habituating," the patients responded more quickly and in general required less, not more, Elixophyllin as time went on.

CONCLUSIONS

No gastric effects were observed in sixteen patients given Elixophyllin. Single doses of 75 to 90 cc. (equivalent to 500 to 600 mg. of aminophylline) were administered orally without gastric effects.

Rapid relief of attacks was secured: in milder attacks in a few minutes; in more severe attacks in 10 to 30 minutes. Status asthmaticus did not respond to the preparation.

Instead of tolerance development it was observed that severe attacks tended to respond in a shorter time (5 to 10 minutes) with continued use.

Wheezing, dyspnea and retrosternal tightness were largely or completely relieved by smaller individually adjusted doses and attacks became less frequent and less severe.

The need for auxiliary aids steadily diminished and was completely abolished in most cases.

The five patients taking hormones were able to discontinue their use after one to two months of Elixophyllin therapy. The number of patients deemed candidates for hormone therapy may be reduced with the use of Elixophyllin.

For relief of wheezing and retrosternal tightness Elixophyllin was found superior to potassium iodide or combinations of aminophylline, ephedrine and sedatives. These advantages were especially noted in elderly debilitated patients with emphysema and chronic bronchitis, who showed an impressive general improvement in health.

Relief in young patients was frequently dramatic. In children, dosage adjusted according to Young's rule was adequate. This provides a vital margin of safety and is in definite contrast to the adult or near-adult doses employed in suppositories.

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CHANGING CONCEPTS IN STAFF-HOSPITAL RELATIONS

CARL BEARSE, M.D., *Boston, Massachusetts*

HISTORICAL BACKGROUND

The subordinate relationship of staffs to hospital governing boards is not a recent development. In fact, it goes back to the founding of the first voluntary hospital in the United States—the Pennsylvania General Hospital—in 1751, 205 years ago.

The Philadelphians who contributed financially to establish this hospital elected a board of managers. The board took upon itself not only the appointment of the physicians who would practice there, but also approval of their competence as practitioners. Today the same system is in effect. Trustees still appoint the medical staff. The only difference is whereas originally the managers personally examined applicants, now they usually depend on the medical staff or its appropriate committee to pass on competence. However, trustees still reserve the right to make staff appointments without approval of the staff or its appropriate committee, and at times exercise that privilege! This happened in a Massachusetts hospital a very few years ago. A man was appointed chief of the obstetrical service although the staff refused to nominate him as a staff member.

The original (3) physicians at the Pennsylvania Hospital were appointed for one year, and served without compensation. Here then was established the precedent of free service to indigent sick. In fact, the original doctors also furnished the medicines. This they did for three years, when the managers decided the hospital should stand this expense. Today appointments are still usually made for one year and today the physician donates his samples to his indigent patients.

The physician who originated the idea of having a voluntary hospital was Dr. Thomas Bond. He was made a member of the original board of managers of the Pennsylvania Hospital. After serving a year in this capacity, he was appointed to the medical staff. When this was done he resigned as a member of the governing board. Thus, in 1751 at the

The Author. *Editor in Chief, Massachusetts Physician*

SUMMARY

The relationship of medical staffs to hospital governing boards is traced from the founding of the first hospital in the United States to the present, indicating the changing concepts which have developed and the resulting strain on staff-trustee relationships.

Eight reasons are given why there should be staff representation on hospital governing boards, and the author even questions whether laymen make any better hospital trustees than do physicians.

Finally, an arrangement is described which exists between the Massachusetts Medical Society and the Massachusetts Hospital Association which serves to protect staff members against summary dismissal and provides a means of appeal from any such action by the trustees.

Pennsylvania General Hospital was established the precedent that physicians, and particularly staff physicians, should not serve on hospital boards of management. Today managing boards are still made up almost exclusively of laymen. Only rarely are there physicians on the boards of trustees and usually they are physicians who are not members of the active staff. And these principles that were established at the Pennsylvania Hospital have been followed more or less by all nonprofit hospitals in this country.

CHANGES IN HOSPITAL CONCEPTS

The original concept of a hospital, however, has undergone quite a change. Originally established "for the reception and cure of poor sick persons whether inhabitants of a community or strangers," today the hospital caters to all, both rich and poor, and today most patients are private patients.

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With this change has come another development. Originally the financial support of hospitals was the responsibility of the managing boards. Today hospital income comes largely from the private patients.

It was to be expected that when the lay boards were responsible for raising funds, they would control the hospital. The hands that hold the purse strings are usually the hands that control. Today, however, it is the medical staff that brings in the money through their private patients, but the lay boards still want no change in control. As a result, all over the country there is increasing dissatisfaction in staff-trustee relations.

Cognizance of this fact was taken by the AMA House of Delegates in December, 1951, when it approved a report that included this sentence: "Since the physician and hospital are interdependent, it is incumbent on both to be interested in all phases of their scientific and financial relationships."

PHYSICIANS AS HOSPITAL TRUSTEES

As long as 25 years ago, Dr. Frank H. Lahey in his address as president of the New England Surgical Society, wrote: "I believe that on every hospital staff there should be several members of the staff who are trustees of the hospital. If the members of the medical profession do not assert an interest in, and accept a responsibility for their economic management, they, the medical men, will be pushed farther and farther down the scale, until they assume the position from which they are not far distant, of 'hired men' more or less—under the power and control of the trustees and hospital superintendents."

The same sentiment was expressed in an editorial in *Philadelphia Medicine* in 1950: "Recent trends in the attitude of many hospital administrators and boards of trustees toward medical staffs of hospitals show an unwillingness to recognize the proper position which the physician plays in the role of the institution. On the contrary, the feeling often persists that the medical staff is merely a service organization, to be handled in a manner which will result favorably to the financial operation of the hospital."

But are physicians qualified to serve as hospital trustees? The American Hospital Association has long been opposed to the idea and originally the American College of Surgeons did not favor it. The reasons given were that (1) membership might give

undue publicity to the individual physician; (2) he might use his position to promote himself on the staff; (3) the staff might come to regard him as an inspector; and then the old saw, (4) finances and business are outside the physician's ken.

Granting that all objections are valid, how much better qualified are laymen to serve as hospital trustees? Raymond P. Sloan, for many years a hospital trustee and editor of *The Modern Hospital* magazine, wrote a guide book for hospital trustees, hospital workers and laymen, called "This Business of Ours." On the subject of physician-trustees, he notes: "Although some parallel can fairly be drawn between hospital operations and that of big business, there is a point at which marked divergencies will be noted. The industrial organization is governed by those who supposedly know their fields. The hospital organization is governed by men and women who have little, if any, knowledge of its professional affairs. The doctor sees a layman possessing little acquaintance with medical science or hospital technique placed in a position where he dictates policies and exercises controls over those who have spent years in acquiring professional knowledge. What could be more inconsistent?" This, mind you, from a lay trustee.

On the other hand, there are many good reasons why physicians should serve on hospital governing boards. Dr. Robert S. Myers, assistant director, *Bulletin of the American College of Surgeons*, enumerates these as follows:

(1) Physicians take their responsibilities seriously and discharge them with distinction.

(2) Physicians have a first-hand knowledge of the needs and deficiencies of hospitals based both on their own observations and the observations of their patients.

(3) Physicians are trained in deductive reasoning and are accustomed to making important decisions—life and death decisions, in fact.

(4) Physicians can best explain medical problems to lay members of the boards. Conference committees afford only limited communication between board and staff.

(5) Physicians are an integral part of the community. As representatives of business, law, clergy, and labor bring to governing boards the benefits of their special training and experience, so would physicians' special knowledge of medicine be of value to the board.

(6) Board membership for physicians would insure the ultimate authority of the governing board and eliminate possible jurisdictional disputes with the medical staff.

(7) Physicians would be taking their share of responsibility for such nonmedical problems as money raising.

(8) There must be a true partnership between hospital and physician. This will not be realized until physicians participate in the management of hospitals and share in the responsibilities attending this privilege.

As to lack of financial know-how, a study of the composition of directors of various corporations and banks will disclose the large number of physicians exercising their financial acumen.

Three years ago the Joint Commission of the Boards of Trustees of the American Medical Association and American Hospital Association, in a report on Hospital-Physician Relationships, suggested various means by which the medical staff could have free and direct access to the governing board. Among the proposed methods was membership of the medical staff on the hospital governing board. And the Stover report, which was approved by the AMA House of Delegates last June, recommended that "physicians should be on the administrative boards of hospitals."

The setup of the Blue Shield Corporation in Massachusetts could well be used as a pattern for hospital governing boards. Of Blue Shield's 18 members, 12 represent labor and industry, and six, or one-third, are physicians. Thus Blue Shield has broad public and medical representation. On hospital governing boards at least three physician-trustees with staggered terms should be elected by the staff. It would be well, too, if these physicians were not permitted to succeed themselves, otherwise they might get to think and act like lifetime lay trustees and forget that they are representing the staff. This system would over the years permit a large percentage of the staff to serve on governing boards and to become better informed of trustees' problems. It would also implement the recommendation of the House of Delegates of the AMA that "every professional man on the appointed staff have a voice in the professional management of the institution." I commend this arrangement for your serious consideration.

PROTECTIVE AGREEMENT BETWEEN ORGANIZED MEDICINE AND HOSPITAL ASSOCIATION

So much for staff-trustee relations. I will now describe an arrangement entered into by the Massachusetts Medical Society and Massachusetts Hospital Association in an effort to provide protection for staff members who might otherwise be dismissed without cause, without a hearing and an opportunity to defend themselves, and without appeal. The conditions which brought about this arrangement are not peculiar to Massachusetts. A change in administration, personal reasons, hospital politics—and you all know what I mean by that—and staff members have been summarily refused reappointment without cause and sometimes have not even been given a reason. There was no method of appeal. Other staff members dared not go to their assistance for fear of similar summary action. The only recourse was indifferent public opinion, and you know how ineffective that is.

The *J. A. M. A.* of September 1, 1956 tells of a physician in Fulton, New York who, after receiving nine annual appointments to the staff, was denied a tenth appointment.

This physician brought suit against the hospital. He contended that denial of appointment would destroy his practice and deprive him of the right to practice medicine in that area and that the action of the hospital governing board was arbitrary, and without due process of law, since he had received no notice and had not been granted a hearing prior to the board's action.

The board maintained that it had complete control in the management of the hospital and "that no court could presume to review or correct its official acts."

The court, however, thought otherwise. It held a physician could not be denied use of a public hospital by unreasonable rules and regulations, such as not giving the physician notice of charges or a hearing prior to its action.

Said the court: ". . . a qualified physician admitted to practice in a public hospital acquires a species of tenure and cannot be capriciously excluded, and thereby injured financially and professionally, without notice and an opportunity to be heard."

The physician was reinstated as a member of the staff for the treatment of his private patients.

The present setup in Massachusetts makes court action of this kind unlikely.

In 1950, the AMA recommended that committees on hospital and professional relations be established on State and county levels. These committees were to receive complaints from any physician, hospital, medical organization or other interested person or group about professional or economic relations existing between physicians and hospitals. Such committees were appointed by the Massachusetts Medical Society and its district societies. (In Massachusetts, these do not quite follow county lines.) Here for the first time in Massachusetts were groups to whom aggrieved staff members could appeal for assistance. And these committees have proved to be of great help to physicians who thought they were not getting a square deal. In two instances, the Society voted to deplore the action of boards of trustees and recommended reinstatement of deposed staff physicians.

In one hospital 15 trustees resigned; a new board of trustees took over and the aggrieved physician was restored to her former position.

The other hospital defied the Society. Since the three physicians involved did not care to pursue the matter, it was dropped. However, the recalcitrant members of this hospital board have also been replaced. This hospital now has an entirely new board of trustees, which includes three members of the active staff. This shows how much governing boards respect the opinion of a State Medical Society.

Two years ago a further step was taken by the Massachusetts Medical Society to assist its members in their relations with hospitals. An agreement was reached with the Massachusetts Hospital Association that no governing board should deprive a physician of staff membership, or reappointment, or change his privileges in any way without informing him of the charges against him, and without previous consideration by the staff. Should the physician involved, or the staff, be unwilling to accept the decision of the governing board, a committee with equal representation from the staff and the governing board is to be formed, on request, to review the case. If this committee is unable to make a majority recommendation, or if any of the parties involved so desire, a request for an opinion at the State level may be made to the president of the Massachusetts Medical Society and to the president

of the Massachusetts Hospital Association. Upon receipt of such a request, the president of the Massachusetts Medical Society is to appoint three members of the Society, none from the staff of the hospital under discussion, and the president of the Massachusetts Hospital Association is to appoint one hospital administrator and two hospital trustees, none from the hospital involved, to act as an appeal board. The six appointed members of this committee select a lay chairman, not a hospital trustee or administrator, but one well known for his interest and activity in civic affairs. The report of this committee is sent to the governing board of the hospital, to the hospital staff, and to the president of the Massachusetts Medical Society and Massachusetts Hospital Association.

As a result of this cooperative action between the Massachusetts Medical Society and the Massachusetts Hospital Association, staff members who feel they have been unjustly treated now have a court of appeal. These procedures, of course, carry no legal force, and are not binding on governing boards of hospitals. However, the moral effect on hospitals belonging to the Massachusetts Hospital Association (and practically all belong) can not help but induce these institutions to abide by the recommendations.

Wrote Dr. Norbert A. Wilhelm, director of Peter Bent Brigham Hospital (*Massachusetts Physician*, August-September, 1956): "People of all walks of life abhor injustice. This recourse reflects a basic American principle long due in hospital and medical circles—the right to be heard when a charge is considered by the accused as unfair or unjust. Thus far the committee's judgment and recommendations have been accepted and respected, and have set a pattern for similar reviews which may from time to time be required. Their activities represent an objective and intelligent approach which has fostered understanding out of suspicion and arbitration out of acrimonious debate."

CONCLUSIONS

1. Staff physicians should concern themselves with the administrative and financial problems of hospitals.
2. Staff representation on governing boards would bring closer cooperation between staff and trustees.
3. A pact, such as described, between Massachusetts Medical Society and Massachusetts Hospital Association should be adopted by all State medical societies and State hospital associations.

ARE HOSPITALS INCREASINGLY ENCROACHING ON THE PRIVATE PRACTICE OF MEDICINE?

J. STANLEY KENNEY, M.D., *New York, N. Y.*

ARE hospitals increasingly encroaching on the private practice of medicine? The answer is yes. But the scope of this topic should be broadened to include other corporate entities, to wit: government (federal and state), foundations, insurance companies, unions, etc., etc.

Physician-hospital relations have long been a bone of contention. They have taken on urgent significance in recent years because of the social changes inherent in our times. This is the era of determined effort by numerous lay and quasigovernmental interests to assume the practice of medicine. This is the era of class struggle, labor strife and socialism against private enterprise. Dr. G. Westbrook Murphy, in his widely circulated address to the North Carolina Medical Association, points this up sharply:

"Unfortunately, we, the medical profession, are 'caught in the middle' as we stand in the way of their expanding programs. The day is not far off when industry, labor, government, insurance companies, hospitals and related groups will combine in their campaigning to control all health activities. If we are not organized into a position of strength, private practice as we have known it will cease to exist."

The American Medical Association, albeit tardily, has evinced a growing interest in this problem of hospital-physician relationships. While it has made pronouncements over the years from time to time, only since 1948, when the Board of Trustees set up a committee, now popularly known as The Hess Committee, has the interest taken on major proportions.

In the first place, the committee set up certain principles based on our Code of Ethics, as a basis for adjusting existing controversies. They might be enumerated here:

1. A physician should not dispose of his professional attainments or services to any hospital, cor-

The Author. *Past President, Medical Society of State of New York; Senior Associate Visiting Physician, St. Vincent's Hospital, New York City; Visiting Physician, St. Elizabeth's Hospital, New York*

SUMMARY

The author has tried to compile in this brief paper the prevailing views presently held by organized medicine in its efforts to resolve this most controversial problem. There are outlined some of the basic philosophies involved. The position of the specialist and the general practitioner in hospital staff organization is discussed. Specific recommendations for an equitable solution are considered, with emphasis on liaison or similar committees, essentially at the local level. Attention is called to the disturbing encroachment on the practice of medicine by many organizations other than hospitals.

poration, or lay body, by whatever name called or however organized, under terms or conditions which permit the sale of services of said physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement, if any, between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

Notwithstanding the wide dissemination of these principles and guides, difficult and even explosive

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controversies have arisen in the field of physician-hospital relations. Much misunderstanding of both purposes and motives in this area of medical care still exist.

So far as can be determined on the basis of study made by the Bureau of Legal Medicine of the AMA, as a matter of law the corporate practice of medicine is illegal in most States. The classic example given by the committee of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a professional man and then sells his services to the public on a fee basis for the profit of the corporation. The primary obligation of both physicians and hospitals is to serve the best interests of the patient. The decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. And second, all the various questions involved in the relationships between physicians and hospitals, both legal and ethical, particularly questions dependent on local conditions, must be considered in the first instance at the local level because of the various differences which of necessity exist in the many sections of this country.

Since the physician and the hospital are interdependent it is incumbent on both to be interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also toward hospital management. The recommendations of the staff concerning medical matters are usually accepted by the management of the hospital through its Board of Managers or Trustees. It also must be remembered that to be approved for residencies in specialties by the Joint Board of Accreditation of Hospitals, certain requirements are mandatory for the institution. This includes adequate training in such services as pathology, radiology, anesthesiology and physical medicine.

The financial problems of the lay hospital management usually have been no affair of the professional staff. This is wrong and frequently is the cause of many of the differences of opinion between physicians and hospital management. The financial problems of an institution in which a physician does his professional work are of importance to him, and proper consideration must be given to these problems if the hospital is to work efficiently and remain

the workshop of the physician. Without proper facilities the services rendered to the public are in jeopardy, and these are the all important function of both hospital and staff. Thus it is evident that every professional man on the appointed staff should have a voice or representation in the professional management of the institution. This makes it imperative that the pathologist, the roentgenologist, the anesthesiologist and the physiatriest—and today the general practitioner—should have equal standing as active members of the staff with all due rights and privileges pertaining thereto. The chiefs of these departments should be nominated and appointed in the same manner as are the chiefs of other major departments in the hospital.

During the past decade or more there have been rapid and perhaps ominous changes in the accepted practices of the hospital in its relationships to medical practice. We are facing, these days, a critical period in which it shall be decided whether the fields of diagnostic and therapeutic medicines shall be dominated by physicians or hospitals. By "hospitals" I mean, as stated at the beginning of these remarks, the institutionalized planning with which we are all familiar and which tends to make the institutions the dominant factor in the delivery of medical services. The trend seems to be towards some type of "institutionalized" medicine with the hospital and the medical school as the central figures. The rapid growth of Blue Cross and Blue Shield plans, particularly the former, has further complicated this already difficult situation. Blue Cross plans serve a most useful purpose, especially where they function in conjunction with voluntary medical care plans. Their danger is their seeming willingness to provide medical services under the guise of hospital care. This is particularly true in the fields of anesthesiology, radiology and clinical laboratory services.

Are such hospital practices perhaps unlawful? Are they violating the law that forbids hospitals to practice medicine? The American Hospital Association and its constituent members say "No;" that these laws do not apply. Courts in a number of States have stated that a corporation does not evade the law against the corporate practice of medicine by hiring a physician.

A most recent incident and one which has attracted national attention is the Iowa Decision on Doctor-Hospital Relations. Time does not permit going into the details of this decision. Suffice it to say that

the medical profession is vitally interested because of the principle involved, namely, that only a physician can practice medicine, and not a corporation. And finally, the physician alone should collect the fees for his services. This is an important safeguard for the public because it fixes the responsibility for patient care directly on the physician involved. The desirability of delivering inhospital medical care through the medium of full-time salaried physicians, from the public welfare point of view is a major concern of medical societies today.

This growing tendency of the medical schools and hospitals to engage in the practice of medicine is a disturbing phenomenon. The morality of this issue is open to question. But aside from this, it has an evil effect on the situation of the general practitioner, whose proper sphere of influence in medical practice is a subject of great interest throughout the country today. The denial to the family doctor of diagnostic and other hospital facilities, except through the medium of a consultant or specialist, tends to presume incompetence on the part of the general practitioner. This trend presents family doctor service as second-rate medicine and decidedly lowers the prestige and confidence the generalists should actually enjoy. No hasty judgments should be reached. We have neither the right nor the desire to dictate hospital policies to hospitals, but we must not permit the forcible translation of medical services into hospital services.

The general practitioner represents a most important branch of medicine; I would say the most important. The increasing activities of the American Academy of General Practice is *prima facie* evidence of this. It is doing much to preserve the good name of the family doctor and restore to him his rightful place in the over-all pattern of medical practice.

The most pertinent facet of this whole picture involves the integration of the general practitioner into hospital staff organization. The growth of specialization and certification of specialists has tended to eliminate private practitioners from hospital staffs. Yet the increasing complexities of modern practice indicate more and more the importance of his role. We need today, more than ever, the highly educated doctor with a broad outlook who knows his patient's family background and his environment and who can view each case in its proper perspective. Such a doctor knows when to seek the

services of a specialist. And the public needs to be educated to seek specialist aid only on the advice of the family physician. There is real danger to the patient who wanders from one specialist to another with no family doctor to guide him.

Continuous postgraduate training must be provided in order that every general practitioner can equip himself to be a more competent diagnostician and acquire these skills which will enable him to perform the more routine procedures that his training and experience entitle him to do. In my opinion, Board certificates should not be the criterion of eligibility for admission to the staff of, nor promotion in, approved hospitals. But the general practitioner must be honestly recognized and competently rated. There is a clear need for a General Practice Section in hospital staff structure, where the G.P. can have voice in shaping the medical and organizational policies of the hospital.

As to what steps should be undertaken to accomplish these constructive purposes and to combat the increasing encroachment by hospitals on the private practice of medicine, and how we can move toward clarification and improvement in the relationships of hospitals and physicians?

In the event of a controversy between physicians and hospital administration or physician and physician, it is recommended that such problems be resolved insofar as possible at the local level. To implement the settlement of such controversies it is recommended that each component county medical society and each constituent State medical association appoint a committee on hospital and professional relations. In many areas, including my own county and State of New York, these committees already exist. In addition, another approach that should not be neglected is the establishment of comparable committees by local and State hospital associations. On receipt of a complaint, the matter should be investigated and acted on in such manner as will best effect equitable adjustment of the complaint. It seems reasonable to assume that county and State medical associations could well effect liaison with these hospital organizations in the settlement of problems involving physician relationships.

A recent example of such liaison was the work of a joint conference committee in Cleveland composed of the Cleveland Academy of Medicine and the Cleveland Hospital Council. The purpose of this committee was to arrive at an agreement compatible

with the local situation and acceptable to both the Society and the Council. The committee apparently considered not only the corporate practice of medicine but the entire question of physician-hospital relationships. An agreement was reached, and it was approved by both bodies. It is now awaiting ratification by two thirds of the trustees of the member hospitals of the Council. In essence this agreement divides the duties and responsibilities of trustees and medical boards; makes clear that all physicians are in the practice of medicine and are to be dealt with on that basis; it would eliminate the corporate practice of medicine by directing the manner of payment of medical fees; and it establishes an impartial board to hear the grievances of both hospitals and doctors, with power of final decision. If these recommendations meet with approval of the hospital group, they might well serve as a pattern for other localities where physician-hospital relations have become an urgent problem. Appeal to court action should be the last resort.

"The public service rendered in voluntary hospitals is adversely affected by the deterioration of their relationships with the physicians who staff them. Their assumption of the guardianship of public health is a necessary rationalization if they are, indeed, to have complete control of inhospital practice. This invasion of private practice, however, has been bitterly resented and is the main cause for the antagonism that now exists. It seems to us that the roles in the community of the hospitals and of the medical profession need re-evaluation."

This is a quotation from an editorial in *New York Medicine*, May 5, 1956. The following are what the editors of this publication believe to be axiomatic in the approach to this difficult problem:

1. Both voluntary hospitals and physicians are responsible for community health. Each group has a proper sphere of activity in discharging this responsibility. Their joint aim should be to render necessary services and to insure that they are of high quality.

2. Hospital administrators and lay executive boards should concern themselves primarily with the providing of an adequate physical plant, in good running order, complete with materiel, equipment, and nonprofessional personnel.

3. The medical staff, on the other hand, should determine the medical needs of the community and recommend ways of providing it. The medical board should supervise and be responsible for all medical services provided in the hospital both by the professional staff and scientific nonprofessional personnel. Such centralization of authority and responsibility will give patients maximum protection.

4. Hospitals should discontinue the corporate practice of medicine since it is not in the public interest. Methods of making financial arrangements with those specialists who render primarily inhospital service should be considered so that they may bill patients directly and reimburse the hospital for the facilities it provides.

5. Charges for hospital care should be put on as realistic a basis as possible, particularly with regard to ward or municipal cases.

6. Medical boards, in cooperation with the local medical societies, should establish rules for staff tenure and provide a mechanism within the hospital for redress of grievances without prejudice. A further mechanism for appeal to a medical society or to a grievance committee of some type should be provided. This would do much to improve staff relationships.

I have previously alluded to the many segments of the community who would tell us how to practice medicine. This, again, demands unity and organization of our own profession. The time is past when individuals or isolated groups can negotiate successfully with these powerful units of society, and I would strongly urge that the State medical societies and/or the county medical societies assume the prerogative of doing their own negotiating with third party agencies.

PHYSICIAN-HOSPITAL RELATIONS

RALPH T. OGDEN, M.D., *Hartford*

*The Author. Radiologist, Hartford Hospital;
President, Connecticut State Medical Society*

MY assignment on this panel discussion of Physician-Hospital Relations is to present the case of the physician who practices a specialty in hospitals under circumstances which organized medicine proclaims cannot serve the best interest of the patient, which encroaches on the private practice of medicine, and which presents a threat to freedom of medical action and decision that is potentially ominous. These specialists, for the most part, are radiologists, anesthesiologists, pathologists, and physiatrists. They are the physicians who, at the present time, are most commonly hired by hospitals to practice their specialties for the profit of hospitals.

I practice one of these specialties. I am a radiologist. I practice with a group of radiologists who have staff appointments in several hospitals. We have a satisfactory fee for service type of practice in all these hospitals. Our relations with hospital administrations are on a high level of equality, friendship, and cooperation. We have no grievance with any of them. I say this to make it clear that I have no ulterior motive and nothing to gain personally for supporting the cause of better hospital-physician relations in general, and for supporting the cause of those hospital employed physicians who are not participating in the profits of their specialty and who would like to do so.

Physicians and hospitals have a common purpose—the care of the sick. They have worked together toward this end with unity of purpose since the first hospital was founded. There was no serious disagreement between them as long as hospitals supplied the facilities for patient care and the doctors administered to the sick with a minimum of hospital regulation. It was not until hospitals began to inject themselves into the practice of medicine in competition with private doctors and began to employ specialists to practice their specialty for the profit of hospitals, that physician-hospital relations began to deteriorate until they have reached the present level of charges, counter charges, and legal proceedings.

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SUMMARY

The common purpose of physicians and hospitals is the care of the sick. Physician-hospital relations did not deteriorate until hospitals entered into competition with private physicians when they employed specialists to practice in the hospital for the latter's profit. This constitutes a master-servant relationship which is not in the best interest of public welfare.

Statutes pertaining to the practice of medicine by nonprofit corporations are confusing. The chief issues at stake between hospitals and physicians involve the economics of medical practice and the principle of third party intervention between patient and physician. The wedge being driven by hospitals practising medicine, unless withdrawn, will end in socialized medicine.

Monopoly of practice by physicians in hospitals need not be completely exclusive and should be controlled by the administration on the advice of the medical staff.

Payment for professional services should be covered by Blue Shield, not by Blue Cross. A satisfactory solution to this entire problem can be attained by hospital associations and the medical profession.

THE MASTER-SERVANT RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN

The major unsettled and debatable question between physicians and hospitals concerns whether it is legal for hospitals to employ physicians to practice medicine for the profit of hospitals, and whether it is morally and ethically right for physicians to enter into agreements with hospitals whereby the specialty in the hospital becomes subject to direction and control by hospital authorities. Organized medicine maintains that such a master-servant relationship, potential or otherwise, is not in the best interest of public welfare.

Statutes pertaining to the practice of medicine by

nonprofit corporations are not always clear or specific. This is true in Connecticut where legal minds have studied the Medical Practice Act and have submitted diametrically different opinions. It is, however, generally agreed by those familiar with the subject that only individuals can be licensed to practice medicine.

If it is legal for hospitals to practice medicine through employees, they are in a position to compete unfairly with physicians who are not on the paid hospital staff. Hospitals can, and some do, urge their private practicing staff members to send office patients to the hospital for diagnostic and therapeutic procedures instead of to the offices of other private practicing physicians. Hospitals with a paid staff of physicians could set the pattern of fees for diagnostic and therapeutic surgical and medical procedures for the whole surrounding area. The public is hospital minded these days and would not hesitate to go to a hospital for medical and surgical care if they could get it cheaper than in the home or private office. It is doubtful that these things are going to happen in Connecticut, but even so, that is no reason to bury heads in the sand and refuse to admit the possibility.

Any situation that places lay authority between physician and patient gives that authority potential power, which, if abused, could affect freedom of medical action in the diagnosis and treatment of disease. Such a possibility may seem ridiculous and preposterous, but there have been instances where complete freedom of action in medical matters has not been permitted by hospital administration. If such a thing can happen some place else and to someone else, even though seemingly insignificant, it can happen anywhere and to anyone. Any circumstance under which such interference is even remotely possible can not assure that the best interest of the patient will be served.

SITUATIONS PRODUCING POOR RELATIONS—ECONOMICS

Medical economics is one of the deep rooted and basic factors contributing to the present and all too frequent unhappy relations between hospitals and specialists. This should be recognized and every effort made to establish on a national level satisfactory terms of agreement between hospitals and physicians so that unhappy consequences of legal proceedings can be avoided.

These specialists in hospitals have many and varied financial arrangements with their institutions, most

of which are ethical and mutually agreeable. Under these circumstances there is no attempt or desire on the part of either hospital administration or specialist to exploit the other. If there is any quarrel between these gentlemen, it is without malice. There are, however, other situations where hospital-physician relations are not so commendable and where administrative authority is exercised in a belligerent and dictatorial manner. These situations are delaying amicable hospital-physician relations and need correction.

Some specialists are paid by salary, which has no direct bearing on the amount of professional services rendered by these physicians or on the charges which the hospital makes to the patient for their services. This is the most socialistic of any of the master-servant arrangements and there is little to recommend it. Others are remunerated on a fee for service basis which is tied to some form of percentage arrangement. This type of agreement can be very satisfactory and can be mutually beneficial. The most acceptable arrangement of any is one wherein the hospital rents space for a department to a staff-approved physician or group of physicians on a business basis. There is no master-servant relationship under these circumstances.

Hospitals would be in a stronger position to refute the charge that they are practicing medicine in competition with local physicians if their employed specialists were participating in the profits of their departments on a fee for service basis. Under these circumstances, the specialist is stimulated to compete with his colleagues outside the hospital. Competition is healthy and good for medicine as it is for business and other professions.

Incentive of some kind is usually necessary to get the best out of most people and doctors are no exception. Economic gain is an incentive that is common to all but this incentive is denied those physicians who are practicing for a fixed income. A few may not need it but nevertheless it is lacking for those who do. There are many instances in private, public and governmental services where one can coast along without too much effort if one lacks the initiative to take advantage of opportunity.

There are those who do not want to compete in private practice but prefer hospital positions in teaching or research. These are special circumstances that must be provided for, but if these physicians practice medicine for a fee for a third party as a part of their teaching or research position, they

should have something to say about the distribution of profits which come from their practices.

The hospital-employed specialists, with few exceptions, are the only physicians who practice medicine in hospitals who are required to give over to hospitals a portion of the professional fees which they earn and which can be earned only by licensed physicians. These fees can accrue as profits to the hospitals only through the services of licensed physicians. The practice of sharing fees with hospitals subjects the physician to the charge of fee splitting which is an unethical practice. These specialists are not uncommonly required to sign agreements that the private practice of their specialty outside of the hospital will be cause for dismissal from the staff. Such actions, which do not apply to all members of the staff, are discriminatory. The salaried hospital specialists are frequently in a category apart from the rest of the medical staff and they are often considered by their colleagues to be more a part of administration than a part of the staff because they are employees of the corporation. When these specialists are hired they frequently have only a yes or no choice concerning the distribution of their earnings and the manner in which they will be remunerated. It is often a take it or leave it proposition and since it is expensive for these specialists to set up in private practice, a reasonably good offer will most often be accepted and a principle will be sacrificed for bread and butter. If these and other discriminatory things can happen to a few specialists now, they could, in time, happen to all physicians who practice medicine and surgery in hospitals. Regardless of whether these things are good or bad for the hospitals, the medical profession or the public, one group of specialists should not be forced to practice in hospitals differently from the rest of the staff.

PRINCIPLE OF THIRD PARTY INTERVENTION

Although there undoubtedly are instances where hospitals exploit physicians and vice versa, by and large this is not the case and income to the specialist from any arrangement may be adequate and may compare favorably with the income of his colleagues. Exploitation by either party is not a healthy thing for good hospital-physician relations and should be condemned. The issue between hospitals and physicians is not entirely one of money and profit. It is also one of principle and the effect which the practice of medicine by nonprofit corporations may have on the future of the private practice of

medicine and the ultimate effect which it may have on the practice of all physicians and not just those specialists who are now on the firing line. The thin edge of the wedge has already been inserted between the specialist and the patient. Unless the wedge is withdrawn, it will be driven deeper and deeper between more physicians and more patients, not only by hospitals but also by industry, unions, government and others, ending in socialized medicine.

MONOPOLY OF PRACTICE

On the other side of the picture it is charged that these specialists have a monopoly and that some make too much money. Exploitation need not exist and it should not be tolerated. Monopoly, however, is not disposed of so easily. Under present circumstances a monopoly exists in most hospitals, regardless of whether the physician has it or the hospital has it. It is usually condemned but it may be expedient if it is for the best interest of the patient and if patients benefit more because of it than they would without it. The decision whether or not to maintain a monopoly should be a combined staff and administration one based upon circumstances.

It is not necessary that a monopoly in hospital practice be completely exclusive. It is possible to have provisions so that staff members could have consultation with other specialists who are not on the active staff, similar to consultations which take place between physicians on the private wards. Every effort should and could be made so that these consultations could take place without disturbing routine organization.

The medical staff should approve and recommend to the administration the specialists with whom they wish to associate and with whom they wish to consult about their patients, and the specialist should be appointed to the staff by the administration the same as all other staff members are appointed. The medical staff should also have an influential voice about the contract which the hospital has with specialists because all patients in hospitals are patients of physicians. They are not patients of the hospitals. They are patients in hospitals.

Regardless of the motivation behind the decision of a person to study medicine, that person expects to profit by it and to have a higher than average standard of living. If he is successful, he gets these things because of the knowledge which he has acquired and his ability to use it. Hospitals cannot have this knowledge except through physicians and they cannot profit from it except through physicians. It

is, therefore, neither illogical nor unreasonable for a hospital-employed physician to expect to participate in profits which he has made possible and which are not possible except through him.

WHERE PAYMENT FOR PROFESSIONAL SERVICES BELONG

Hospitals in Connecticut could make an outstanding contribution to better hospital-physician relations if they would join with physicians in a combined effort to remove professional service payments from Blue Cross and provide for their coverage in Connecticut Medical Service. Refusal to collect

these fees would force Blue Cross to abandon coverage of the practice of medicine or to pay the physician directly for his professional services.

It is possible for the hospital associations and the medical profession to work out a program for practice by specialists in hospitals which would allow a free choice of physician, which would eliminate exploitation and monopoly, and which would exonerate hospitals from the charge that they are injecting themselves into the practice of medicine. It is being done in Iowa.

THE GENERAL PRACTITIONER IN HOSPITAL PRACTICE

R. B. ELGOSIN, M.D., *Hamden*

The Author. *President of the Connecticut Chapter of the American Academy of General Practice*

SUMMARY

A definition of a general practitioner is offered and from a recent report to the President's Commission on the Health Needs of the Nation is quoted a classification of general practitioners. Hospital practice is then defined. Omitting government and proprietary hospitals, the types of nonprofit general hospitals are listed.

Attention is called to the fact that the place of general practice in hospital practice depends on the hospital Board of Trustees, the Administrator, and the Executive Committee of the Medical Staff. The attitude of the Joint Commission on Accreditation of Hospitals and of the American Medical Association is emphasized whereby hospitals are urged to give attention to staff appointment of general practitioners on the basis of their demonstrated ability and training.

The percentage of general practitioners holding staff appointments in Connecticut hospitals is quoted from a recent survey made by the Connecticut Chapter of the American Academy of General Practice. An appeal is made for closer cooperation among ourselves as a profession with the hospitals in an effort to produce the tender, loving, medical care the public wants at a price it can pay.

THE subject for discussion is of great importance to every doctor, whether a specialist or a general practitioner, and to every tax paying citizen, present and future. A great amount of work has been done and is being done by the American Medical Association, the American Hospital Association, the American College of Surgeons and the American Academy of General Practice to find the best solutions to the problems created by expanding medical services and a society conscious of the need for medical care, yet fearful of their ability to pay for it individually. The practical result desired by the patient, the specialist, the generalist, the hospital administrator, the hospital board of trustees is the same: good medical care provided in a practical, efficient, yet understanding manner. Since the desired aim of all concerned is the same, the solution is possible, providing everyone concerned meets in a spirit of trust, respect, and understanding of the problems of each other. The solutions will not be found in personal animosities and emotionalism.

Before discussing the subject of general practice in hospital practice as it should be and as it is, it might be wise to define words so that we shall all know what we mean when we use words such as general practice and hospital practice.

DEFINITION OF TERMS

What is general practice? One definition of a general practitioner, or generalist, is that he is a legally qualified doctor of medicine who does not limit his practice to a particular field of medicine or

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surgery. In his general capacity as family physician and medical advisor, he may, however, devote particular attention to one or more special fields, recognizing at the same time the need for consulting with qualified specialists when the medical situation exceeds the capacities of his own training or experience. This definition is not perfect and requires qualifications. Clark and Collings in their report to the President's Commission on the Health Needs of the Nation describe the general practitioners as of three classes:

1. The general practitioner who, after graduation has had one or two years of hospital training and then entered community practice. The community practice may be urban, suburban, or rural and depending on the social, economic and professional situations in each locality, the general practitioner becomes a certain type of general practitioner.

2. This class of general practitioner includes the physician with additional training in internal medicine, such as a year or more of residency training in an approved hospital before going into community practice. Again one must realize that the social, economic and professional environment where he practices determines in large measure the type of general practitioner.

3. This class comprises the general practitioner-specialist who has reached specialist status by virtue of training (such as qualification by the American Board of Internal Medicine), but more frequently he has developed advanced skills in a particular direction, for example, surgery, obstetrics and anesthesiology, by diligent application, by postgraduate studies, and by years of experience.

Thus in terms of the lack of a specific definition of a general practitioner, or general practice, as stated above, it becomes impossible obviously to come to a conclusion about general practice in hospital practice except by detailed analysis of each general practitioner.

Hospital Practice Definition: Hospitals are of three types: 1. Government hospitals are supported by tax funds and are operated under the direction of federal, state, city, or county government. 2. Proprietary hospitals are operated for profit by one or more doctors or other individuals. 3. Voluntary nonprofit hospitals which may be either general hospitals or special hospitals for specific diseases.

Government and proprietary hospitals are excluded in our discussion of hospital practice. But then, what type of voluntary nonprofit general hospital should we include in our discussion of hospital practice? The U. S. Public Health Service in its

report under the Hospital Survey and Construction Act of 1946 placed general hospitals ideally in the following groups (some of which we have now but are not designated as such):

1. The general hospital associated with a medical school and university. This is the Medical Center serving as a medium for medical and public health education.

2. This is the district general hospital having all the necessary equipment for diagnoses and treatment. Other general hospitals in the area would use this hospital for consultation and referral of certain patients.

3. This is the community or rural hospital which offers limited types of service and which would be served by the district hospital.

4. This would not strictly be classified as a general hospital but would be a rural community clinic and would provide limited emergency service with facilities for minor surgery and obstetrics. Such small hospitals would work closely with community and district hospitals and would likewise house the administrative public health offices.

The reason for including such a division of general hospitals (really not a division but an integration of the hospital and health services) is to make clear that these are changing times and any attempt to project general practice, or for that matter, any physician in any type of practice, into the hospital practice of the future would be most difficult.

FUNCTION OF BOARD OF TRUSTEES

Even today the place of general practice in hospital practice by any definition depends primarily on the hospital Board of Trustees, and indirectly on the Administrator, and on the Chiefs of Services comprising the Medical Board, or Executive Committee of the medical staff.

The Board of Trustees are legally and morally responsible for the type of hospital care provided for the people of the community. Supreme Court decisions have upheld the right of the Board to exclude any doctor without reason. The decisions in essence state that the hospital is not maintained for the convenience of physicians but for the care of patients and the Board of Trustees as representatives of the owner, the public, can select staff members without interference since court interference would absolve the Board of its responsibility of providing proper care for patients. The Board of Trustees usually approves the recommendations for appointment brought to them by the Administrator from the Medical Board.

QUALIFICATIONS FOR HOSPITAL APPOINTMENT

The procedure for application for appointment to the medical staff is defined in the Medical Staff By-laws. The Joint Commission on Accreditation of Hospitals and the American Medical Association through its Council on Medical Education and Hospitals both encourage hospital staff rules which permit the general practitioner staff-member privileges in the specialty departments in keeping with his merit and demonstrated ability. From the Council's "Essentials of Approved Residencies and Fellowships" is the following: "The particular specialties in which residents are being trained should be represented in the staff by well qualified, experienced and proficient physicians, whether or not they hold membership in special societies and colleges or are certified in their specialty." Certification is only a relative indication of a physicians proficiency.

The answer to "What should be the place of General Practice in Hospital Practice?" is provided in an understanding of what has been said and the obvious conclusion that the general practitioner, and any specialist for that matter, should be integrated in the hospital staff so as to be permitted to provide medical and surgical care for his patients according to his training and demonstrated ability as judged by the Medical and Tissue Audit Committees and his colleagues. Opportunity should be present for education and advancement for all doctors. Appointments to the medical staff are on a yearly basis, and the doctor who neglects to assume his responsibilities for the privilege of working in the hospital, of improving his knowledge and ability, and of providing better medical and surgical care for his patients can be placed on probation or removed from the medical staff. This applies to all doctors.

The primary aim of all concerned is to provide good medical care to the patient, whether in the hospital, in the office, or in the home. This aim is defeated when any doctor practices medicine without being on a hospital staff for he then loses the incentive to improve himself and as a result his patients in the years to come do not get good medical care. One wonders if the day is not too far distant when the certified internist, whom many would have you believe erroneously is the general practitioner of the future, will find that he is unable to get an hospital appointment. Or the certified surgeon find himself in the same position in some cities. This should not be a fight between specialist and specialist, or specialist and generalist, or doctors against administrators and boards of trustees. These problems require the best effort of all concerned to

find solutions to provide better medical care for the people in the years to come without government interference. If we cannot find satisfactory ways, the government will take over while we are divided; and the people will still pay the taxes . . . but they will be higher.

GENERAL PRACTICE IN CONNECTICUT HOSPITALS

What is the status of general practice in hospital practice in Connecticut today? The Connecticut Chapter of the American Academy of General Practice conducted a survey of its members in the spring of 1956. About 200 members replied, and one of the questions related to Hospital Staff Appointments. 28.3 per cent of the General Practitioners were on the Attending Staff. 35.1 per cent were Assistant Attending. 4.2 per cent were Clinical Assistant Attending. 32.5 per cent were on the Courtesy Staff. No members reported no staff appointments.

86.5 per cent of the doctors reported that their hospital privileges were adequate; but this requires qualification. Some younger doctors in practice where the hospitals were closed to them for surgery may have been trained to do limited work in certain surgical fields and may have desired to increase their ability in these fields; but were unable to do so because of local hospital regulations. Older doctors still doing surgery found that some of their privileges had been removed without regard to their ability proven through the years; so, although voting yes, they would still like to have the opportunity of advancement in hospital privileges.

The present situation in Connecticut varies from the large cities to the smaller communities but undoubtedly in each case of hospital vs. medical staff difficulties, each side raises the banner of "Better Medical Care For The Patient." It reminds one that many a war has been fought with the "Flag of God" on each side making it a Holy War. We know that nobody really wins in a war. Everybody loses something.

In our present difficulties of a changing society, social security consciousness, third party payments, rising costs of hospital care, rapid medical advances, medical specialization and medical groups, resurgence of the general practitioner, and the peoples desire for tender, loving, medical care, at a cost they can afford to pay, let's not fight among ourselves or with others. Why not follow the example of the great leaders in the various medical and hospital organizations and work together for a common cause so we may have fewer sick people and more happy, healthy people for our patients and friends.

165th ANNUAL MEETING
of the
CONNECTICUT STATE MEDICAL SOCIETY

EAST HARTFORD HIGH SCHOOL

777 Burnside Avenue, East Hartford, Connecticut

April 30, May 1, 2, 1957

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PRELIMINARY PROGRAM

Tuesday, April 30

AUDITORIUM

ANNUAL MEETING OF THE HOUSE OF DELEGATES

COLE B. GIBSON, *Meriden, Speaker of the House, presiding*

10:00 CALL TO ORDER

BUSINESS SESSION

1:00 LUNCHEON FOR OFFICERS, MEMBERS OF THE HOUSE, AND GUESTS

2:00 RESUMPTION OF BUSINESS

7:00 ANNUAL DINNER OF THE COUNCIL

Wednesday, May 1

9:00 REGISTRATION

AUDITORIUM

9:15 CALL TO ORDER—President of the Society

ADDRESS OF WELCOME—President of the Hartford County Medical Association

9:45 TRANQUILIZING DRUGS

John Donnelly, *Hartford, Connecticut*

10:25 MANAGEMENT OF THE NEPHROTIC SYNDROME

Arnold S. Relman, *Boston, Massachusetts*

11:05 INTERMISSION TO VISIT TECHNICAL EXHIBITS

11:20 USE AND ABUSE OF LABORATORY PROCEDURES

David Seligson, *Philadelphia, Pennsylvania*

12:00 PANEL ON MEDICAL CARE INSURANCE: ITS INFLUENCE ON MEDICAL SERVICE

THOMAS J. DANAHY, *Torrington, presiding*Donald Stubbs, *Washington, D. C.*Norman A. Welch, *Boston, Massachusetts*Mr. Louis A. Orsini, *New York, New York*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

PROGRAM ARRANGED BY CONNECTICUT CHAPTER—AMERICAN ACADEMY OF
GENERAL PRACTICE*President: Richard B. Elgosin, Hamden**Secretary: Peter J. Scafarello, Hartford*RICHARD B. ELGOSIN, *Hamden, presiding*

2:00 AN APPROACH TO THE PATIENT WITH HEADACHE

Perry S. MacNeal, *Philadelphia, Pennsylvania*2:40 AS THE INTERNIST LOOKS AT THE LUNG CANCER PROBLEM: AN ANALYSIS OF 300 CONSECUTIVE
TISSUE PROVEN CASESJ. Antrim Crellin, *Philadelphia, Pennsylvania*

3:20 Discussion

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

3:30 Section on Dermatology and Syphilology

Section on Gastroenterology

Connecticut Association of Medical Record Librarians

Connecticut Branch—American Association of Medical Social Workers

Connecticut Diabetes Association

Connecticut Occupational Therapy Association

Connecticut Regional Group—Medical Library Association

Hezekiah Beardsley Pediatric Club

7:00 ANNUAL DINNER OF THE SOCIETY — Hartford Club

Thursday, May 2

9:30 REGISTRATION

AUDITORIUM

- 10:00 ESTIMATION OF OPERATIVE RISK, 1957
 SURGICAL ASPECTS—J. Garrot Allen, *Chicago, Illinois*
 MEDICAL ASPECTS—Clarence E. de la Chapelle, *New York, New York*
 ANESTHESIA—Nicholas M. Green, *New Haven, Connecticut*
- 11:15 INTERMISSION TO VISIT TECHNICAL EXHIBITS
- 11:30 THE CHANGING PICTURE OF PULMONARY SURGERY
 Julian Johnson, *Philadelphia, Pennsylvania*
- 12:05 MANAGEMENT OF ULCERATIVE COLITIS
 SURGICAL ASPECTS—Paul Nemir, Jr., *Philadelphia, Pennsylvania*
 MEDICAL ASPECTS—Henry J. Tumen, *Philadelphia, Pennsylvania*
- 1:00 LUNCHEON—Cafeteria of the High School
 VISIT TO TECHNICAL EXHIBITS

PROGRAM ARRANGED BY THE CONNECTICUT SOCIETY OF AMERICAN BOARD SURGEONS

President: E. Cotton Rawls, *Greenwich*

Secretary: Eugene J. Fitzpatrick, *New Haven*

- 2:00 VASCULAR EMERGENCIES OF INTEREST TO THE GENERAL PHYSICIAN: THEIR RECOGNITION AND TREATMENT
 Harris B. Shumacker, Jr., *Indianapolis, Indiana*
- 2:40 COMMON ERRORS IN THE DIAGNOSIS OF ACUTE ABDOMEN
 Samuel J. Stabins, *Rochester, New York*

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

- Section on Anesthesia
 Eye, Ear, Nose and Throat Section
 Section on Industrial Health
 Section on Obstetrics and Gynecology
 Connecticut Society of American Board Obstetricians and Gynecologists } Joint Meeting
 Section on Orthopedics } Joint Meeting
 Section on Radiology } Joint Meeting
 Connecticut Society of Pathologists } Joint Meeting
 Association of Medical Examiners of Connecticut } Joint Meeting
 Section on Physical Medicine
 Connecticut District Branch of The American Psychiatric Association
 Section on Urology
 Connecticut Allergy Society
 Connecticut Chapter—American Physical Therapy Association

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

The 1767 Medical Corporation of Litchfield

By the time the apprentice system of medical training was under way in the Colonies it is likely that intercommunication between the doctors of an area was not infrequent. This would be the natural result of friendships formed between preceptor and student and between practitioners who had served apprenticeships together. It would be natural too for doctors living in the same area and trained in what was the best medical tradition of the day to seek to protect themselves and their patients from exploitation by charlatans and other irregulars who sought to capitalize on human ills. Early attempts to establish medical societies in Connecticut are largely lost in obscurity. One of these which can be said to have died aborning occurred in Norwich in 1763 when eleven physicians unsuccessfully petitioned the colonial Legislature for a medical society charter. That something similar was going on in Litchfield County about this time has been the speculation of medical historians for a long time. In 1936, Dr. Walter Steiner speaking before the Litchfield County Medical Association referred to the address of Judge Samuel Church given at the Litchfield County Centennial in 1851. At that time Judge Church stated that, "as early as January 1767, a Medical association was formed in this County composed of the most eminent physicians then in practice here." Dr. Steiner's comment was, "Where the original documents are that gave him (Dr. Church) this information has never been revealed."

And now Dr. Byron Stookey of Sharon comes

along with the very information that Dr. Steiner and the others sought for so long. Dr. Stookey's paper is an important historical document which reflects careful research. More than this it gives us a stimulating and interesting picture of medical goings-on in Litchfield County in 1767 when the doctors there founded a medical society and carried it on as a successful enterprise for at least five years.

Dr. Stookey's research has also revealed another discovery in the address of Dr. Seth Bird, which as far as is known is the first record of a paper given before a medical society in our State. It has other interest for us for it shows the style of medical writing of that day and also what doctors had to listen to at a medical meeting.

It is fitting that the CONNECTICUT STATE MEDICAL JOURNAL should have the privilege of presenting this paper for a number of the physicians whom Dr. Stookey talks about later became listed among the first members of the Connecticut Medical Society.

Physician-Hospital Relations

The relationship between physician and hospital has been a subject of considerable discussion in recent years. Pursuant to encouragement from the House of Delegates of the American Medical Association, several hospitals have established joint conference committees with the Boards of Trustees. These have had a salutary effect on the relationship between the medical staff and the hospital administration, including trustees, directors, etc. Some have advocated membership on the Board of

Trustees by representatives from the medical staff. This latter point of view was supported by Professor John P. Amsden of Dartmouth College, formerly president of the Mary Hitchcock Hospital in Hanover, New Hampshire. In an article entitled "Trustee-Staff Relationship" appearing in the *JOURNAL* in July, 1956, Professor Amsden says: "My personal experience has convinced me that the presence of a staff member on the Board of Trustees of the hospital is the best means of assuring a continuing interchange of ideas and an awareness of each other's problems."

It is not surprising that the New Haven County Medical Association should devote the program of its recent semi-annual meeting to a symposium on "Physician-Hospital Relations." With the advent of a third party entering into the payment of both hospital and medical services, there is increased need for maintaining an atmosphere of mutual understanding and good faith between hospital administrators and practising physicians. Elsewhere in this issue will be found the text of the four papers presented at Meriden, two by medical leaders from neighboring States and two by members of our own Society and leaders in medicine in Connecticut.

In reading these four papers one should never lose sight of the fact that the hospital exists solely for the welfare of the patient and that the trustees and the physicians are equal partners in this enterprise. Anything that will foster in these two groups a feeling of sharing together in the problems and accomplishments of hospital operation must be nurtured if the community hospital is to survive as a voluntary, nonprofit institution and medical care continue on the high level it has attained.

Support the Increased State Cancer Budget

The biennial recurrence of the meetings of the Connecticut General Assembly mean budget time for all of the State agencies. Budget of the State Department of Health has always appealed to the legislators as a safe place to make savings when economies are demanded. Our citizens in general being unfamiliar with the problems involved, and our medical profession in particular who should have a special interest and knowledge, but who maintain for the most part a studied indifference, are not apt to react strongly to the failures to increase appropriations for this Department in recent years.

Your attention is directed particularly to one item in the budget of the Division of Cancer and Other Chronic Diseases for which an increase has been sought unsuccessfully at every legislature since 1945. This is for a sum of money which, although it may seem inconsiderable in the light of budgetary figures we are used to reading nowadays, has a direct bearing on the continuance of a program which has achieved an importance truly out of proportion to the small expenditure. It is the grant made annually to the thirty general hospitals in Connecticut which operate cancer clinics and cancer registries to aid in the support of these activities and also to help in providing needed diagnostic services for indigent cancer patients.

The maintenance of such registries in general hospitals today is one of the factors considered by the Committee on Accreditation when they grant the certificate of approval for intern training. The figures collected by the Division of Cancer through a purely voluntary arrangement with these hospitals have been utilized and cited by cancer research workers throughout the world as being unique in their scope and validity. The funds available are divided between the hospitals on a point basis, which reflects the activity of the particular hospital in registering and treating cancer patients. Since these funds have for many years been less than would allow for all to share proportionately on this basis, a maximum has been established for the grant to the larger hospitals.

The total amount of money which is thus divided was set at \$50,000 annually by the legislature in 1943. It has not been increased since then in spite of the fact that the case load of cancer patients has increased over 100 per cent, and the cost of living index has increased over 50 per cent. The modest increase to \$75,000 annually, which is currently requested, will not actually be enough to take care of the normal progression of salary increases since 1945 for those workers whose salaries are paid in full or in part by these funds. Those physicians interested in the continuance of this essential work are urged to communicate directly with their local legislators, indicating their support of this appropriation.

Only 50 per cent of the total budget of the Division of Cancer has been made up from the legislative grant, the remainder being supplied from federal funds. These funds, which originally

amounted to about \$40,000, have steadily decreased to about \$25,000 annually. This is in accordance with the established policy to continue reducing these federal grants until such operations are entirely supported by the individual states. It can thus be seen that far from there being any possible surplus in the Division of Cancer which could be applied to the support of the cancer clinic and registry program, there is an urgent need to increase the direct support of the whole Division by the Connecticut General Assembly.

Theophylline in Allergy

It is infrequently that our readers will find on the pages of this JOURNAL any one manufacturer's product advocated to the point of boosting. Perhaps we may be absolved from criticism on the basis that this is a rather common practice today among medical journals in the United States. A recent issue of our leading national journal contained four articles discussing a certain proprietary drug and its uses.

In this issue of the JOURNAL appears a paper written by one of the members of our State Society advocating the use of a certain theophylline preparation. In a series of 17 cases he records striking success in 15 patients. In such a short series as this, one must always look at the results with a somewhat critical eye, but if we follow Alan Gregg's formula to be applied in reading case reports the author in this instance far surpasses the required margin of acceptance.

The use of alcohol in the preparation as advocated for children may raise in the minds of some of our readers a question of abuse. In answer to this, in a personal communication from the author, we are informed that the use of alcohol as an auxiliary agent in combination with more potent drugs precludes any possibility of its abuse. This auxiliary use makes it possible to avoid greater dangers of other therapeutic agents.

The author goes on to say:

The adult dose of 75 cc. for an acute attack contains very little alcohol and this dose could not be soon repeated, because the mean theophylline blood levels have been shown to be higher at 15 minutes, 30 and 60 minutes after administration than obtained with 250 mgms. of Aminophylline i.v. or 500 mgms. of Aminophylline i.m. At the end of four hours the levels were comparable to those of i.m. Aminophylline at the same period, and were still in the

therapeutic range. (These data will be published soon.) Another similar dose taken during this time would induce theophylline intoxication and vomiting.

It is this dependable and rapid absorption that produces effective results with a fraction of the theophylline dosage commonly used in children. (I call your attention to Dr. Nolke's paper in the *J. A. M. A.*, June 23, 1956: "Severe toxic effects from aminophylline and theophylline suppositories in children.") Wheezing is therefore quickly relieved. This permits avoidance of CNS stimulants and consequently avoidance of barbitals to counteract the sympathomimetics. The rather small dose of rapidly oxidized alcohol should be preferred to the more or less constant barbitol depression. A significant point which I observed is that the patients need less and less with constant management instead of more and more of other medications.

Common Economic Poisons

The number of chemical substances that find their way into common use is increasing daily. Many of these have profound effects on mankind when accidentally ingested or as the result of over exposure by contact or inhalation. Interest in this subject and the hazards to the public is growing and knowledge of their action has kept pace with their use. They present a new problem in human morbidity and mortality.

Evidence of this interest is shown by two bills now before the General Assembly. One bill, SB60 and HB162, prescribes labelling of hazardous substances for the protection of the public. The other, HB194, would create a poison information center in the State Department of Health. The Society is working for the passage of both of them.

Physicians would do well to have immediately at hand information concerning the content of common household chemicals, pesticides, solvents and rodenticides. A volume, "Clinical Memoranda on Economic Poisons," prepared by the Technical Department Laboratories of the United States Public Health Services is available. It has been printed for distribution by the National Agricultural Chemical Association. This book contains discussions of the chemical content of common substances, symptoms produced when people are exposed to them, their antidotes and recommended treatment. Copies can be obtained in the office of the secretary of the Society, 160 St. Ronan Street, New Haven.

The Greek Physician Damianos Sotiriades

It is not an unusual occurrence for the editor to receive a medical journal printed entirely in a foreign tongue. To be a modern and really efficient medical editor one should be able to read Polish, Ukrainian, Finnish, Danish, Italian, Spanish, not to mention French and German, for all these tongues are represented by the publications which come across the editor's desk.

The latest such medical journal is one from Athens printed entirely in Greek—except for the final article on Damianos Sotiriades. *Academic Medicine*, the Greek journal in point, has embarked upon a course in which it plans "to bring forward some of these great Greek doctors without academic laurels, particularly in recognition of the highest honor due to them for their long, successful and fruitful scientific career as well as for their incessant efforts and sacrifices for the nation, their free services to destitute patients and their socio-medical work in general, and partly for enlightening the younger colleagues and suggesting high standards of excellence for initiation."

Hence we have the first of this series devoted to Damianos Sotiriades, physician, research worker, public health leader.

The Etiology of Cancer

If one does not subscribe to Dr. A. C. Ivy's theory that the reticuloendothelial system can be made to produce in the blood stream a growth regulating hormone which, when extracted, can be used effectively to treat cancer, one must pause to consider two new approaches to the etiology of cancer. At the Third National Cancer Conference held in Detroit in June, 1956, Nobel Prize winner Wendell M. Stanley of the University of California expressed the opinion that experimental evidence now available is consistent with the idea that viruses are the etiological agents of most, if not all, cancer, including cancer in man. Viruses as the cause of cancer were suggested by such investigators as Duran-Reynals and Oberling many years ago. Now Dr. Stanley reports that evidence for the virus etiology of cancer has come from so many different laboratories and has been of such good quality and quantity that it is difficult for him to understand why so many investigators have disregarded this evidence. Where many have been willing to accept

viruses as etiological agents for animal cancers, few have been willing to consider them of etiological importance in human cancers.

At the recent meeting of the American Association for the Advancement of Science held in New York City another etiological factor in the production of cancer was reported. Dr. Felix Wroblewski of the Sloan-Kettering Institute suggested the possibility that cancer eventually may be detected in its premalignant and preinvasive stages by a measurement of enzymes in tissue and blood. Dr. Wroblewski reported that an increase in lactic dehydrogenase is found in body fluids other than blood when cancer cells are present in the fluid or in adjoining tissues. These findings have led this investigator to believe that herein may lie a possible opportunity to diagnose malignant neoplasms in their prodromal or noninvasive phase, even before they are recognizable histologically.

These new developments in cancer research are of the utmost importance to every one of us. The evaluation of these theories must be left to the research clinician but the practising physician should know of these developments since the public is being exposed to this knowledge through the lay press.

Indiana Journal Reaches Age of Fifty

This is the Golden Anniversary year of the *Journal* of the Indiana State Medical Association. As with our own JOURNAL, Indiana's was founded to replace its annual Transactions. Unlike Connecticut, however, Indiana's baby was two years from conception to birth. At the age of fifty it merits due esteem and reverence from one which this year arrives at the mature age of twenty one.

Much thought and careful planning went into the establishment of the Hoosier publication. The fifteen members of the Council responsible for this accomplishment wrought well. We offer our cordial greetings on this Golden Anniversary.

Erratum

Recommendations from Committee on Eye Care as published on pages 140 and 141 of February issue: 1st word, 2nd line, page 141 should read *stereoscope* and not *stethoscope* so that 3c will read as follows: "Depth perception: Polaroid vectrograph or stereoscope for 3^d fusion."

PROGRESS IN CLINICAL MEDICINE

AGAMMAGLOBULINEMIA AND ABNORMAL GLOBULINS

Their Detection and Significance

HAROLD O. CONN, M.D., *New Haven*

The Author. *Instructor, Department of Internal Medicine, Yale University School of Medicine, New Haven, Connecticut*

AGAMMAGLOBULINEMIA was originally recognized by Bruton¹ in 1952 and was quickly established as a clinical entity by Bruton, Janeway and co-authors.^{2,3} Since these early descriptions more than fifty cases of this syndrome have been reported.⁴ Many of these patients have been carefully studied to delineate further the clinical features and the immunologic deficits, and to clarify the basic mechanisms of antibody production. The purpose of this communication is to review briefly the current concepts of these diseases.

The gamma globulin fraction was so named because its migration in the Tiselius electrophoretic apparatus was the slowest of the three globulin components (see Figure 1). Although not all the constituents of this component have been identified, it is known that most of the circulating antibodies are gamma globulins. If this antibody-containing material were deficient or absent one might anticipate enhanced susceptibility to infection. This appears to be the case in agammaglobulinemia.

The term agammaglobulinemia, which has already become firmly entrenched, is a misnomer. General usage has defined it as the absence of gamma globulins by electrophoretic methods. However, it has been demonstrated by immunologic techniques, which are much more sensitive, that small amounts of gamma globulins (2-100 mg. per 100 cc.) are present in these cases. Nevertheless, the name congenital agammaglobulinemia is universally accepted. There is, however, a growing tendency to refer to the acquired types as hypogammaglobulinemia.

Congenital agammaglobulinemia, the disease originally described, and acquired agammaglobulinemia, a related disorder which was recognized subsequently, are the most important clinically. Of less importance are a variety of diseases associated with hypogammaglobulinemia. A provisional classification of these syndromes is presented, based on the approximate amounts of gamma globulin pres-

SUMMARY

The relationship of extremely depressed levels of gamma globulins and enhanced susceptibility to infection is known as agammaglobulinemia. Congenital inability to produce antibodies, which make up the bulk of gamma globulins, was originally thought to be responsible. Subsequent observations and investigations have indicated that acquired varieties may be more common and more important clinically.

Hypogammaglobulinemia may occur spontaneously or in association with a variety of diseases. In some of these diseases, such as the nephrotic syndrome, increased susceptibility to infection occurs. In others, the patients appear normally resistant to infection. Recurrent infections occur in some patients in spite of abnormally elevated levels of gamma globulins. It is postulated that these immunologically abnormal globulins are formed at the expense of normal antibodies.

The recognition of these clinical syndromes and their underlying defects have greatly extended our knowledge of immunologic mechanisms.

ent (Table I). This classification is arranged to emphasize that these entities form a wide spectrum of disorders of protein metabolism, ranging from almost complete absence of gamma globulin to gross hypergammaglobulinemia.

TABLE I
CLASSIFICATION OF QUANTITATIVE DISORDERS OF GAMMA GLOBULINS

- I. Congenital Agammaglobulinemia^{1,2,3,4} (<30 mg. per 100 cc.)
- II. Acquired Agammaglobulinemia (<200 mg. per 100 cc.)

A. Hypogammaglobulinemia associated with a decrease in other serum proteins.

1. Nutritional Hypoproteinemia.⁵
2. Nephrotic Hypoproteinemia.^{6,7}
3. Hypercatabolic Hypoproteinemia.^{8,9}
4. Idiopathic Hypoproteinemia.^{10,11,12}

B. Hypogammaglobulinemia associated with normal levels of other serum proteins.

1. Infantile Hypogammaglobulinemia.^{1,13,14}
2. Idiopathic Acquired Hypogammaglobulinemia.
15,16,17

Normal (600-1300 mg. per 100 cc.)

III. Dysgammaglobulinemia Associated with Hyperglobulinemia (<1500 mg. per 100 cc.)

A. Neoplastic dysgammaglobulinemia.^{18,19}

B. Idiopathic dysgammaglobulinemia.²⁰

Congenital agammaglobulinemia, like hemophilia, appears to be a sex-linked recessive hereditary defect, transmitted by females and exhibited by males. It is characterized by the appearance during infancy of a severe lack of resistance to infection. These patients are predisposed to develop bacterial infections, particularly pneumococcal pneumonia and meningococcal meningitis, as well as sinusitis, otitis, and enteritis. They apparently are less susceptible to viral than to bacterial infections,^{19,21} although cases with severe chronic viral hepatitis^{4,16} and recurrent epidemic parotitis have occurred.² Neutropenia, which may be transient, cyclic or persistent occurs in some cases.²¹ Lymphopenia and eosinopenia have been described.^{4,16} Some have shown thrombocytosis, the significance of which is unknown.²²

The intramuscular administration of gamma globulin may entirely suppress the susceptibility to infection.

The immunologic status in congenital agammaglobulinemia has been termed "immunologic paralysis."²¹ The defects of antibody production include the failure to develop antibodies after viral or bacterial infection, or in response to immunizing antigens usually capable of stimulating antibody production. Patients with congenital agammaglobulinemia fail to develop complement fixing antibodies after having had mumps, and display no humoral antibodies after stimulation with brucella, pneumococcal, typhoid, or viral antigens. Their Schick tests remain positive even after repeated injections of diphtheria toxoid.

These patients do not have, and appear unable to produce, serum isohemagglutinins against red blood cells of incompatible types. On this basis they appear to be universal recipients of blood transfusions.⁴

On similar grounds they may be successful recipients of tissue homotransplants.²³ Histologic studies have shown that their reticuloendothelial tissues do not respond normally to antigenic stimulation, particularly in the failure of the development in lymph glands of active germinal centers.^{4,24} Plasma cells, which are extremely rare in all the tissues of these patients, do not appear after infection or antigenic stimulation as they do normally. Adrenocortical function has been shown to be normal.^{17,21}

Acquired agammaglobulinemia may be due to a variety of causes. Several types, not always accompanied by enhanced susceptibility to infection, are associated with hypoalbuminemia and possibly other protein deficiencies. These include nutritional hypoproteinemia in which insufficient dietary proteins are available for normal protein synthesis, and nephrotic hypoproteinemia in which serum proteins are lost in the urine. Recently a disease has been described in infants in which serum proteins are destroyed abnormally rapidly.⁸ This syndrome which appears to be of transitory nature may be tentatively called hypercatabolic hypoproteinemia. In addition, some patients may develop idiopathic hypoproteinemia for reasons which are not clear, although hepatic dysfunction has been suspected.⁴

One of the subgroups of acquired agammaglobulinemia without other associated protein deficiencies is infantile hypogammaglobulinemia. This transient state develops between the second and fifth month of life after the serum gamma globulin acquired from the mother has been utilized, but before endogenous antibody production has begun. This group does not ordinarily display increased susceptibility to infection although several cases of fatal vaccinia have occurred during this transient deficiency.^{13,14} It has been suggested that some unexplained deaths in infancy may be related to this defect.²⁵

In idiopathic acquired hypogammaglobulinemia patients at any age, and of either sex, without apparent cause may suddenly exhibit extreme susceptibility to infection. A perpetual series of severe bacterial infections ensues. Recurrent pneumonitis frequently occurs and bronchiectasis may result. As in the congenital variety, tuberculosis has so far not been found.* These patients appear to have little or no gamma globulin electrophoretically, although the

*Tuberculosis has been recently described in patients with both congenital and acquired agammaglobulinemia by Zimmerman, H. H., and Hall, W. H. (Am. Rev. Tuberc. and Pul. Dis., 74:773, 1956.)

other protein components are probably normal. Determined immunologically the gamma globulins range from 2-100 mg. per 100 cc. There are insufficient data to relate the absolute level of gamma globulins to the degree of infection proneness. Unlike the congenital type, they frequently develop splenomegaly^{15,17,26,27} and occasionally hypersplenism,^{17,28} which may be treated successfully by splenectomy^{15,29} or splenic irradiation.³⁰ One has shown granulomata of lymph glands, spleen and liver suggesting sarcoidosis^{15,29} and another showed non-specific hepatic granulomata.³¹ A thymoma was found in two patients⁴ and a radiosensitive mediastinal mass, otherwise unidentified, in another.¹⁷

Patients with idiopathic acquired agammaglobulinemia have been said to have an "immunologic paresis," a similar but less severe defect than those with the congenital disorder, although antibody production in occasional cases may be completely absent.²¹ Some residual antibody production can be demonstrated. Low serum isohemagglutinin titers may be present and small amounts of humoral antibodies may develop. In response to transplantation of skin, one patient at first accepted the transplant but eventually displayed delayed rejection.²¹ It was postulated that reduced responsiveness resulted in delayed development of antibodies to the foreign, antigenic tissue. In most other immunologic aspects they resemble the congenital group.

At the far end of the spectrum are several groups of patients in whom increased susceptibility to infection is accompanied by hyperglobulinemia. One of these groups, neoplastic dysgammaglobulinemia, is seen in myelomatosis,^{18,32} lymphatic leukemia¹⁹ and related disorders^{19,26} in which abnormal, immunologically inefficient globulins are produced at the expense of normal gamma globulin. These patients are particularly susceptible to pneumococcal infections. It is presumed that these neoplastic cells produce abnormal proteins which are similar enough to normal gamma globulin to retain its electrophoretic mobility and even to crossreact with it immunologically, but are incapable of producing normal antibodies. Occasionally, hypogammaglobulinemia will occur in these patients in the absence of abnormal protein components.^{19,33} Finally, idiopathic dysgammaglobulinemia has only recently been described.²⁰ These children exhibit the severe susceptibility to infection characteristic of agammaglobulinemia. However, the gamma globulins in these patients are abnormally elevated. Patients with this poorly understood disorder exhibit hepato-

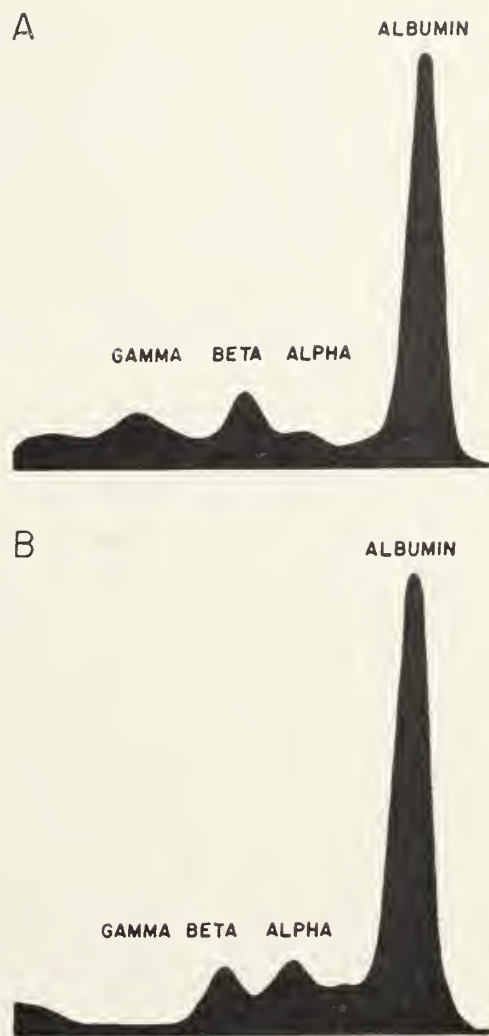


FIGURE 1

Tiselius electrophoretic patterns of human serum. A. Normal serum. B. Serum from a patient with idiopathic acquired hypogammaglobulinemia, showing no gamma globulin component.

splenomegaly and lymphadenopathy. In contrast to patients with agammaglobulinemia they appear to develop antibodies normally and they display a plethora of plasma cells in all tissues.

The diagnosis of agammaglobulinemia is usually suggested by the apparently endless succession of infections. However, the physical examination and the routine laboratory data are normal. Fractionation of serum proteins may show hypoglobulinemia or levels in the lower range of normal. The use of the classical Tiselius electrophoresis method or the simpler, more available, filter paper technique establishes the diagnosis. These techniques, in addition to demonstrating the decreased or absent gamma

globulins, may show generalized hypoproteinemia or the more characteristic hypoalbuminemia and hypogammaglobulinemia of nephrosis. Similarly, dysgammaglobulinemia may be suggested by the classical narrow peak of multiple myeloma, or the more heterogeneous increase of gamma globulin seen in the idiopathic variety. For quantitative measurements, the immunologic technique utilizing anti-gamma globulin serum, is the method of choice. These levels of gamma globulin may be of some value in exact classification, although these diagnoses are best established on clinical grounds. A very useful screening test is the absence of isohemagglutinins against heterologous blood groups. If the patient's blood type is A, B, or O, the isohemagglutinins against incompatible erythrocytes may be significantly depressed or absent, even after the patient is challenged by a small injection of incompatible blood. Kunkel's zinc turbidity test for gamma globulins is another valuable screening test. A positive Schick test may be of value in patients who have been previously immunized against diphtheria. The inability to develop antibodies after routine immunizations, as well as the absence of plasma cells in the bone marrow, or the histologic abnormalities of lymphoid tissue may confirm the diagnosis.

The administration of exogenous gamma globulin has been shown to be specific treatment. Therapy is aimed at maintaining the circulating level of gamma globulins at 100 to 150 mg. per 100 cc. This may be accomplished by the intramuscular administration of 0.1 cc. of gamma globulin per kilogram of body weight every three to four weeks. In spite of this therapy some patients have required prophylactic antibiotic therapy to prevent infections. Some authors favor more generous gamma globulin therapy.¹⁷

The significance of agammaglobulinemia transcends the handful of unfortunate patients who develop this disorder. Viewed as a discrete metabolic abnormality, this disease serves as a stimulus and a tool for investigation of some of the basic problems of protein metabolism and antibody production. Problems concerning the sites of formation of antibodies, and the cells which produce them may be solved. One hypothesis compatible with the clinical and histologic features of these disorders suggests that defects in the maturation of the hematopoietic reticulum results in the failure of the development of plasma cells and lymphocytes, and consequently, of antibodies.

Conceivably, elucidation of the factors which control antibody production may lead to a wide variety of clinical applications. Perhaps diminishing the antibody potential may be helpful in the treatment of hyperimmune disorders and allergic diseases. Conversely, intensification of antibody production may prove of value as an adjunct to immunization. The lack of antibody stimulation has apparently permitted the successful homotransplantation of skin to patients with congenital agammaglobulinemia. The transplantations of lymph glands which were able to form antibodies would appear to be capable of curing these patients. Such attempts, although transiently successful, have failed.^{24,25} Perhaps of greater significance, these advances may offer a new avenue of approach to the successful transplantation of most human tissues, a dream which could revolutionize medicine.

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Determination of "Total and Permanent Disability" in Social Security

New and very rigid medical criteria have just been released to cover both the Disability Freeze program as well as the new cash benefits to disabled persons. These new medical standards mean that only those who are truly and severely disabled will be able to meet the criteria and thereby receive disability benefits. This could have the effect of putting some family physicians on the spot in the eyes of the applicant, since a finding of no disability may conflict with the physician's advice to the patient not to work. This could be avoided to a large extent if there is an understanding at the outset by all applicants that the medical criteria, as suggested by Congress and actually set up by the Social Security Administration, are rigid. This becomes especially obvious when comparing them to the relatively lenient medical standards of the Veterans Administration for disability. If an applicant disagrees with a finding of no disability, he may so state and his case will be reviewed by the same State and Federal Boards for reconsideration. If he is still denied, the case is then referred to a Federal referee and thereafter to the courts if desired by the applicant.

It has been the responsibility of the applicant to provide the medical information for disability evaluation. Currently, however, new policy is being adopted, that of allowing the State agency to purchase medical information and/or tests from the patient's physician, or, if necessary, a consultant, if there is a reasonable expectation of a finding of disability.

Decline in Cancer Mortality

The Metropolitan Life Insurance Company statisticians have reported a downward trend over the past 10 years in the cancer death rate among women in middle life. Among the company's millions of industrial policyholders, mortality from all types of cancer was down by 13 per cent for women at ages 45 to 64 over the ten year period. There has been a one third decline in the death rate from uterine cancer in this age bracket.

While the cancer death rate for middle aged women declined, that for men rose somewhat. This was due principally to increased mortality among males from cancer of the lung, buccal cavity, stomach, and urinary organs.

THE PRESIDENT'S PAGE

IT is difficult to understand why there are physicians in active practice who are not members of the American Medical Association particularly in times like these when organized sources outside the medical profession threaten freedom of action by the physician and the public in matters pertaining to medical care and hospitalization.

Those who do not belong to the American Medical Association should give the matter some serious consideration immediately because a strong representative and united medical organization was never more necessary than it is now to make sure that the practice of medicine rests in the hands of those who are most qualified to preserve the present high standards of medical care.

The American Medical Association is the representative body of all physicians in the United States of America. It has more than thirty Councils, Bureaus and Departments that have studied and gathered information on countless subjects that affect medical practice and it is the only medical organization which has the necessary prestige, influence and background to represent American Medicine.

Membership is not compulsory and it does not necessarily indicate approval of every action which the House of Delegates takes. Those physicians who belong do so voluntarily, either because they believe in the aims and objectives of the Association or in the need of a national organization to represent American Medicine. Dues, however, are necessary to run the organization, to maintain service bureaus, and to publish the JOURNAL, but they are small compared to the services which they make available to the doctor as an individual, the profession as a whole, and the community.

Most matters that come before the House of Delegates of the American Medical Association are, to some degree, controversial and it cannot be expected that one hundred and sixty thousand physicians in this country will agree with all the actions of the majority. Nevertheless, every physician benefits in one way or another from the activities of the Association and those physicians who are in active practice and who do not belong to the American Medical Association are receiving a free ride and are being carried along by their colleagues who do belong.

The business of the American Medical Association is carried out by a house of delegates made up of representative physicians from the members of the State Medical Societies, who are also members of the American Medical Association, on the ratio of one delegate for each one thousand physicians, or fractions thereof. If every physician in Connecticut who is in active practice belonged to the American Medical Association, Connecticut could have another delegate to represent it at the meetings of the House of Delegates. Another delegate is another voice to represent medical thinking in Connecticut, and another voice would be desirable, but unless every active physician in Connecticut becomes a member, another delegate is not possible and Connecticut Medicine cannot be fully represented.

Socio-economic trends today are such that physicians must not only know how to diagnose and treat disease, they must also be prepared to protect themselves and the public from those who would tell them how to do it.

Ralph T. Ogden, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

Telephones: UN 5-0587, LO 2-0836

CALL

ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1957 Annual Meeting of the House of Delegates will be held in the auditorium of the East Hartford High School, East Hartford, commencing at 10:00 o'clock in the morning of Tuesday, April 30.

Following luncheon, the House will reconvene for the completion of business.

Ralph T. Ogden, President
Creighton Barker, Secretary

INTRODUCTION OF RESOLUTIONS

Article VII, Section 4 of the By-Laws of the Society provides:

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual, or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual, or special meeting by the Council and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of paragraphs 1 and 2 of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

THE COUNCIL RECOMMENDS THAT THE BY-LAWS OF THE SOCIETY BE AMENDED SO THAT:

Article V, Section 5, Par. 1, shall read "Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article IX, Section 3, Par. 6, Honorary members shall not pay dues to the Society or vote or hold office."

Article IX, Section 3, Par. 6, a new Section 6 shall be added as follows: "The Council may present

annually to the House of Delegates the names of not more than three eminent physicians as candidates for Honorary Membership in the Society. The Council may recommend the bestowal of an Honorary Degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution to human welfare."

Article IX, Sec. 3, Par. 6, shall become Par. 7.

Article X, Section 1, Par. 1, is amended by the deletion of "A Committee on Honorary Members and Degrees."

Article X, Section 1, Par. 2, is amended by the addition of this sentence at the end of the paragraph. "In the event of vacancy in membership or chairman of these committees such vacancy shall be filled by appointment by the Council to hold office until the next annual or semi-annual meeting of the House of Delegates."

Article X, Section 2, Par. 1, is amended by the addition of this sentence at the end of the paragraph. "In the event of vacancy in membership or chairman of special committees elected by the House of Delegates such vacancy shall be filled by appointment by the Council to hold office until the next annual or semi-annual meeting of the House of Delegates."

Article X, Section 3, Par. 4. This paragraph to be deleted in its entirety and the following paragraphs 5 to 16 inclusive be renumbered.

Article X, Sec., 3, Par. 12, be amended as follows:

"The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee. The membership of this Committee shall include a chairman, one member from the cancer committee of each general hospital in Connecticut, and shall at all times include the President of the Connecticut Cancer Society and a representative of the State Department of Health. This Committee shall be governed by an Executive Committee designated by the Council, which shall include the chairman, President of the Connecticut Cancer Society, representative of the State Department of Health, and six members selected from the other membership of the Committee. The purpose of this Committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut, to aid and encourage the establishment and maintenance of high professional standards in the cancer clinics of the general hospitals, and to organize and promote professional education regarding cancer in Connecticut."

Delegates to Annual Meeting

The By-Laws of the Society provide that each County association is entitled to one delegate in the House of Delegates for each thirty-five members in the association or fraction thereof based on the membership as of December 31 of each year. According to this, the quota of delegates from each county association who should attend the Annual

Meeting of the House of Delegates which will be held in East Hartford, April 30 and the Semi-Annual Meeting in December is as follows:

COUNTY	MEMBERSHIP DECEMBER 31, 1956	OFFICIAL DELEGATES
Fairfield	783	23
Hartford	918	27
Litchfield	130	4
Middlesex	107	4
New Haven	892	26
New London	174	5
Tolland	20	1
Windham	64	2

Election of Councilors and Alternate Councilors

Councilors and Alternate Councilors should be elected for a term of two years at the annual meeting of the county associations this year in Hartford, Middlesex, New London and Windham counties. No Councilor or Alternate Councilor elected by a county association shall serve more than three successive terms of two years each in his respective office, but after a lapse of one term of two years, such Councilor or Alternate Councilor may be eligible for re-election.

Appointment to Committee on Professional Relations

The By-Laws require that the county associations in Hartford, Middlesex, New London and Windham counties at their annual meeting in 1957 elect a past-president of the association to serve for two years on the State Committee on Professional Relations. No member of the Council of the State Medical Society is eligible for election to this committee and no member shall be elected to serve two consecutive terms.

January Council Minutes

The monthly meeting of the Council was held at the offices of the Society on January 31, 1957 and was called to order by the chairman at 4:00 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Ogden, Walker, Barker, Weld, Danaher, Murdock, Gibson, Stringfield, Gallivan, Tracy, Otis, Archambault, Ottenheimer, Gens, Clarke, Meyers, Buckley, Starr, Gillman. Absent: Couch, Feeney, Ursone, Kristan, Dwyer.

A report of the 1956 Clinical Congress was presented and it was noted that although the Congress last year showed a profit of \$808.24 that it would have operated at a deficit of about \$540 if there had been no commercial exhibit. The secretary presented the plans for the 1957 Congress as developed in a meeting of the Committee on Postgraduate Education which was held on January 30. The committee proposes that the 1957 Congress be held at the Hotel Stratfield, Bridgeport, in November. The Council voted to approve this proposal.

A report of the Building Fund was presented.

Dr. Edwin R. Connors, Bridgeport and Dr. Edward R. Howe, Hartford, were nominated to be members of the Professional Policy Committee of Connecticut Medical Service each for a term of three years. During the discussion of these nominations, the secretary presented a letter from Dr. Maxwell Bogin of the Connecticut Chapter of the American Academy of Pediatrics in which it was requested that a pediatrician be named to the Professional Policy Committee. This proposal was discussed by several and Dr. Danaher, president of Connecticut Medical Service, explained the plan for rotation of representation of the various specialties on the Professional Policy Committee.

Dr. Buckley reported on a meeting of the conference committee with the representatives of the Connecticut Osteopathic Association. That report is a part of these minutes. After discussion of the report and the purposes of such a committee, it was voted, on motion of Dr. Gallivan, to "Approve the principle of a permanent conference committee with representatives of the Connecticut Osteopathic Association and direct the executive secretary to ask the governing body of that Association to indicate its sentiments on the matter and its recommendations as to the methods of appointment of members, composition, naming of chairman, scope of activities and similar details."

A brief report on the operation of MEDICARE was presented by the secretary.

A request from Dr. James Peters, chief of the Bureau of Rehabilitation of the State Department of Education for medical advisory committee to the Bureau was presented. The purpose of this medical advisory committee would be to aid the Bureau in the administration of the permanent total disability section of the Social Security Act which becomes operative July 1, 1957. It was voted to establish such a committee and the chairman was directed to

appoint five members to the committee.

Dr. Weld, chairman, presented a report of the Council's Subcommittee on the report of the Hospital Committee. This report was accepted.

Dr. Weld explained the delay and difficulty in obtaining the pro and con articles relating to compulsory social security coverage for physicians that were directed by the House of Delegates on December 6, 1956 to be published in the State JOURNAL. The House of Delegates directed that these articles be published singly in consecutive issues of the JOURNAL. Dr. Weld explained the impracticability of doing this and asked the Council's approval of publishing both articles in the same issue, preferably March. The Council voted favorably on this request.

Dr. Gibson reported in detail recent conclusions reached by the Council's Subcommittee to study the organization and operation of the Society's committees. Dr. Gibson asked that the report be considered a progress report only and not final but it did contain certain definite recommendations.

a. That the standing committee on Honorary Members and Degrees be discontinued and the functions of the committee assigned to the Council.

b. That the Committee on Psychiatric Services in General Hospitals be discontinued and its functions transferred to the standing committee on Mental Health.

c. That the By-Laws of the Society be amended to empower the Council to make appointments to fill vacancies occurring on committees.

d. That the Cancer Coordinating Committee be reorganized in accordance with the plan proposed by the Cancer Coordinating Committee and that the By-Laws be amended to accomplish this reorganization.

Appropriate amendments to the By-Laws had been prepared and were approved by the Council for publication in the March issue of the State JOURNAL and presentation to the House of Delegates at its annual meeting on April 30 of this year.

The report of the Nominating Committee, Dr. Fincke, chairman, was presented by the secretary. It included nominations for all officers and committees for the year 1957-58. It was approved as presented and will be submitted to the House of Delegates at its annual meeting on April 30.

Dr. Robert R. Keeney, chairman of the Society's committee on Public Health appeared before the

Council by invitation to report on the American Medical Association conference on poliomyelitis inoculation that was held in Chicago on January 26. Dr. Keeney attended the conference as the representative of this Society. The conference had been held for the purpose of encouraging State Medical Societies to establish programs urging protection by poliomyelitis vaccine for all persons in the country. Dr. Keeney's report was discussed briefly. It was voted to request the Committee on Public Health to prepare a program for universal poliomyelitis inoculation for the people in Connecticut and to submit this proposed program to the Council for review at its next meeting.

The secretary reported briefly concerning legislation now pending before the 1957 Connecticut General Assembly and explained the procedure that would be followed in the near future by the Society's Committee on State Legislation. Particular reference was made to SB404, a bill prepared and introduced by the Board of Directors of Connecticut Medical Service. This bill would amend the enabling act under which medical service corporations operate and if passed would permit Connecticut Medical Service to provide the coverage to its subscribers for hospital, nursing care, drugs and other health services. The Council voted its approval of this measure and instructed the secretary to support its passage.

Three student members were elected.

We voted that the next meeting of the Council be scheduled for Thursday, February 21, 1957.

The meeting adjourned at 6:30 following which a buffet supper was served for members of the Council and guests including David B. Allman, Atlantic City, New Jersey, president-elect of the American Medical Association.

STUDENT MEMBERS

William E. Davis, Jr., Fairfield
McGill University—1960
Pre-Med: Middlebury College
Parent: William E. Davis (deceased)

Benjamin J. Feola, Stratford
University of Maryland—1960
Pre-Med: Wesleyan University
Parent: Benny P. Feola

Joseph D. Howard, Hartford
University of Kansas—1960
Pre-Med: University of Chicago
Parent: Joseph J. Howard

Meetings Held During February

- February 4—Conference Committee with State Bar Association
- February 6—Committee on Industrial Health
- February 11—Committee on Eye Care
- February 13—Committee on Accident Prevention
- February 14—Committee on Public Health
Committee on Third Party Payments
Committee on School Health
Connecticut Medical Service Executive Committee
- February 19—Board of Directors of Connecticut Medical Service
- February 20—Committee on Perinatal Morbidity and Mortality
Committee on Maternal Mortality
Committee on State Legislation
- February 25—Board of Directors of Women's Auxiliary
- February 27—Committee on Postgraduate Education
- February 28—Subcommittee on Report of the Hospital Committee
Council

New Member

Dr. William W. Bassford, 569 Main Street, Watertown, Connecticut. Elected new member Litchfield County January 22, 1957.

Dr. Meeker Appointed to AMA Committee

The Board of Trustees of the American Medical Association has appointed D. Olan Meeker, Riverside, to be the New England regional member of the Association's Committee on Legislation. It is known by all who have watched Dr. Meeker's work as Chairman of National Legislation of this Society that he is well qualified for the appointment. His interest in national affairs began early in life when his father was a representative in the Congress of the United States, and his knowledge of Federal health legislation is broad.

The AMA turns to Connecticut often for members of technical committees and councils and Dr. Meeker joins a group of hard working, skillful people.

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Pursuant to a Resolution Passed By the House of Delegates of the State Medical Society on December 6, 1956 the following two articles, the one opposed to and the other in favor of Social Security for Physicians, are herewith published for the information of the members prior to the holding of a Referendum by mail, conducted by the Executive Secretary

THE CASE AGAINST COMPULSORY SOCIAL SECURITY

D. OLAN MEEKER, M.D., *Riverside*

SOCIAL SECURITY IS NOT INSURANCE

Insurance is "a contract whereby one party undertakes to indemnify or guarantee another against loss by a contingent event; also, the business of making such contracts."¹

An insurance company makes a contract (policy) with a customer (policy holder) to do certain specific things upon the payment of a fee (premium). There are many laws on the books in the various States making it mandatory that the money which the insurance company receives (premiums) can be invested only in certain ways, that the surplus money on hand must be in a certain ratio to the benefits concerned, that the contract (policy) is irrevocable after the lapse of a certain length of time during which there has been a regular payment of the fees (premiums).

Let us compare this safely guarded contract with "Social Security Insurance."

"Like Social Security 'insurance,' or veteran's 'insurance,' that proposed by the governors (flood insurance) would be accompanied with taxes. The propaganda would call these taxes 'premiums,' but the fact is that these payments would be dropped into the general coffers of the Treasury where the money would be available for any and all government expenses. It would be spent with the usual alacrity. Then the government would set up a 'reserve fund,' consisting of its own bonds in an amount equal to the flood insurance tax receipts. The interest on these bonds—which comes from new taxes—would be used to pay losses; if this interest should not be enough to indemnify the 'insured,'

some of the 'reserve' would be liquidated. In short, any government 'insurance' project is merely a new way of collecting taxes."²

Can't you see that with such internal circular financing there must be a gimmick somewhere to make it go?

The monies collected on the social security tax have gone the same route—into the general fund for spending, then the creation of a special government fund controlled by a board of trustees holding government bonds substituting for actual monies paid into the Social Security Administration. As of today, the "fund," nebulous as it is, totals about \$22 billion. Which shell is the pea under?

Insurance companies are forbidden by law to change their fees (premium rates) after the contract (policy) has been issued and the initial payment of money has put the policy in force. This is not true of government Social Security "insurance."

"One fact that is not advanced with the claims by the advocates of Social Security to include physicians should give you real cause for concern. The Social Security tax base figure has risen 40 per cent in just five years. In 1950 the maximum earned income on which you paid Social Security taxes was \$3,000. By 1955 it was up to \$4,200. A proposal now before Congress would raise it up to \$4,800 this year. Absolutely nothing in the laws prohibits Congress from raising this figure each year.

"Can you think of any good political reasons for not increasing the social security tax rates even beyond the Cooper (1955) bill changes?

"We could not. Therefore, in our determination

of Social Security costs for the physician, we came to these conclusions:

(1) The present laws guarantee that the Social Security tax rate will increase. (It was revised upward as recently as 1954.)

(2) The 40 per cent rise in the Social Security tax base in the last five years sets the historical pattern for similar increases in the tax base in the future.

(3) Political expediency demands further increases in both the Social Security tax rates and tax base figures. Witness the new law initiating the payment of full Social Security benefits at age 50. This new tax dedicated to disability benefits raises the scheduled Social Security tax increases for employees, employers and self employed as follows:

NEW SOCIAL SECURITY TAX RATES UNDER SOCIAL SECURITY BILL HR7225, SIGNED AUGUST 1, 1956⁴

	TOTAL PER CENT	EMPLOYEES PER CENT	EMPLOYERS PER CENT	SELF- EMPLOYED PER CENT
1956	4	2	2	3
1957	4 $\frac{1}{2}$	2 $\frac{1}{4}$	2 $\frac{1}{4}$	3 $\frac{3}{8}$
1960	5 $\frac{1}{2}$	2 $\frac{3}{4}$	2 $\frac{3}{4}$	4 $\frac{1}{8}$
1965	6 $\frac{1}{2}$	3 $\frac{1}{4}$	3 $\frac{1}{4}$	4 $\frac{7}{8}$
1970	7 $\frac{1}{2}$	3 $\frac{3}{4}$	3 $\frac{3}{4}$	5 $\frac{5}{8}$
1975	8 $\frac{1}{2}$	4 $\frac{1}{4}$	4 $\frac{1}{4}$	6 $\frac{3}{8}$

You might figure your payments on the basis of increased tax base figures; it runs pretty high for what you can get out of it as compared to a legal contract, insurance.³

(4) We're goin' to get 'em, sure as shootin'!

"How high will they go? Your guess is certainly as good as ours; but on the basis of a \$1,200 rise in five years, the tax base figure would be \$9,000 by 1975."³

With the new tax law, 6 $\frac{3}{4}$ per cent, that would be \$607.50 a year for your Social Security tax alone! Ask your insurance agent how much insurance you can get on renewable term for that amount. Remember, also, Social Security tax comes off the top—no deductibles there!

"If you figure a 40 per cent rise from the previous Social Security tax base figure every five years, your tax base figure would be \$22,588.61 by 1979. Six per cent of \$22,588.61 would equal a Social Security tax of \$1,355.32 per year. If the tax rate had risen to 10 per cent by then, the tax would be \$2,258.86 per year."³

"A third way to estimate future costs, based on

recent Social Security history, would be to add \$600 each year to the tax base figure. In 1954, \$600 was added. A proposal before Congress now (1956) would add another \$600 in 1956. (Note: this was put into law.) Using this progression, the tax base figure would be:

1960.....	\$ 7,200
1965.....	\$10,200
1970.....	\$13,200
1975.....	\$16,200 ³

Six and three-quarters per cent of \$16,200 would equal a social security tax of \$1,093.50. Remember also that 9 per cent tax rate has been suggested for 1975.

The same increasing tax rate and tax base occurred in the countries which have followed the "Minimum Standards of Social Security" adopted by the International Labor Organization several years ago . . .

Estimates indicates that such a program in this country would cost a minimum of 30 per cent and as much as 40 per cent of payroll. What is 40 per cent of your net income before taxes? The rate is 35 per cent of much of France's payroll now. Some South American countries that have adopted just parts of the International Labor Organization's program have taxes as high as 25 per cent today.³

During the limited debate on the floor of the House when HR7225 was introduced under gag rule of 20 minutes for each side, it was brought out by Mr. Jenkins⁵ that "in order to finance the multi-billion dollar increase in benefits contained in this bill, a higher tax schedule is provided. . . . As a result, the ultimate tax rate projected under the bill, effective in 1975, is 9 per cent, shared equally by employees and their employers . . .

"As high as these future rates are, the rates themselves do not convey a complete picture of the true burden which they involve. The tax on wages is a tax on gross wages, without any allowance for personal deductions, dependents or other deductions. The tax on self-employment income only permits certain business deductions, such as depreciation. It is, in effect, a tax on adjusted gross income. Therefore, unlike the income tax, the Social Security tax is not limited to net income. As a result, that tax, as a percentage of net income, is substantially higher than the actual rates would indicate. In fact, the eventual 6 $\frac{3}{4}$ per cent rate on the self employed would be the equivalent of a net income tax in the neighborhood of 20 per cent and higher in many cases.⁵

"Employees and self-employed persons covered by Social Security do not have an insurance contract with the Government. The Attorney General made this clear in 1937 when he said: ' . . . the Act creates no contractual obligation with respect to the payment of benefits.'

"According to Federal law, Social Security benefits can be reduced or cut off entirely at any time by the Congress of the United States.

"The Social Security Act states in Section 1104: 'The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.'

"Social Security taxes are compulsory, but the Congress of the United States is not under any compulsion to pay benefits. The Social Security Act compels employees and the self employed to pay taxes. The law does not promise anything in return."

It does not seem necessary to belabor further the total difference between insurance, a contract, and Social Security, a tax law. Actually, instead of our system being an "insurance" system in which each participant pays the cost of his own benefits, we have a plan in which the working population pays taxes into the fund to be used for the payments of the nonworking aged population.

Few if any recipients of the old-age pension at present have paid more than about five per cent of the actual cost of their pensions. On the average, the total of employee and employer taxes is about 4 per cent of the cost.

"The remaining 96 per cent of benefits has been paid, and is being paid, out of the taxes of the present workers. The pensions to these present workers, in turn, will have to be paid for by the taxes of the next generation of workers. While the system has accumulated a small excess of income over outgo leaving a reserve fund of some \$19 billion, the experts indicate that this is not enough to pay the rest of the benefits to those now receiving old-age pensions and that the accumulated and undisclosed liability for pensions to all those who have paid taxes, amounts to more than \$200 billion."

Can you possibly imagine State laws allowing any insurance company to work on a deficit financing program like that?

SOCIAL SECURITY DOES NOT REFUND AS MUCH AS LIFE
INSURANCE FOR THE SAME COST

You may have heard that as soon as you join Social Security you get nearly \$37,000 of life insur-

ance coverage. You may not have been told that to qualify for this maximum family coverage you must pay maximum Social Security taxes for 18 months. Then, to get the full benefit, your wife must give birth to twins the day after the 18 months period of payment is completed and, also, you must die on the same day. Rather hard on you, but maybe it will be worth it. Let's see.

Your widow and twins would be paid survivors' benefits of \$200 per month for 18 years which totals \$36,920. But be sure you read the fine print in your Social Security "policy." First, your widow must apply for the survivor's benefits. (The insurance company policy is in force the minute you pay your first premium, even if it is only a quarterly premium; your widow does not have to apply for benefits, they are paid automatically.) Your wife might be attractive enough to remarry; if she does she no longer can receive Social Security benefits. (Insurance benefits do not vary with the marital status of the widow, the contract and obligation cannot be voided.)

If either of the twins marries before 18, he or she receives no further benefits. Of course you know that the children do not receive any more benefits under Social Security after 18. (Insurance companies do not have either of these restrictions.) Oh yes, your widow will not get any more benefits after the twins are 18 until she reaches 65 when she becomes eligible for the munificent sum of \$81 per month.

There are other strings on this grab-bag affair put out by Social Security, strings that if they were attached to an insurance policy would totally prevent the sale of a single policy.

For instance, if either of the twins or your widow earns more than \$1,200 per year, the maximum benefits drop. If she or either of the twins earns \$2,080.01 or more per year, no survivors' benefits will be paid to the earner. If any one of the three earns over \$400 per year, Social Security tax must be paid.

There are certain other "hookers" under the Social Security act. Remember that the system is compulsory—all of us would be forced to pay. (This is not so with the clergy who have voluntary choice as to whether they wish to join the scheme or not. Also, no government employee is eligible for Social Security.) The tax bite is the same whether you have dependents or not. Of course, a dependent parent over 65 could receive benefits after your

death at \$81.40 per month. If you die without issue, as the lawyers say, your wife will receive no benefit till she reaches 65. To make it brief, you are compelled to pay the Social Security tax whether you might benefit or not.

The amount of the benefit payment in each case is computed by formulas known only to the Social Security Administration. In a handbook they issued "simplifying" the laws for laymen there was stated: "There is no single rule for determining whether a person is performing substantial services in self employment. There are many factors to be considered for different kinds of trades and businesses. The Social Security Administration will make decisions based on the particular facts in each case." Does this sound exact enough for you to depend on in planning your family security? What does your widow do when she runs into the "fine print?"³

Let's get down the figures—cash on the line and what you can get for it. The best man to tell you these comparisons is your insurance agent, particularly if he is a man who is a specialist on estate planning. But here are a few minor facts about death from the insurance versus Social Security.

Let us use Dr. Doakes, whose wife has had twins at the end of 18 months of paying Social Security tax, and said Joe is R.I.P. the same day—the only way he, or rather his widow, can get the thin layer of cream off O.A.S.I. (Old Age and Survivors' Insurance).

Joe made over \$5,000 per year and he had paid the Social Security tax for 18 months prior to his demise. His investment in Social Security was:

1956	\$126
1957 (6 months)	63
Total	\$189

Now let's agree that you want the most protection for the lowest cost. To make things seem equal to the Social Security benefits let's say you want \$200 per month for your widow for 20 years of child raising. One thing you should remember is this: To protect your family, your life insurance should be a progressively decreasing need. At the start of a program you might need a twenty year income for your family, but five years later you will need only fifteen years' coverage.

The ideal policy to pay \$200 per month for 20 years would total \$38,000 policy face value at the

start. There are several ways of buying a policy. Let's look at the various costs:

POLICY	ANNUAL PREMIUM
20 year endowment.....	\$1,745
20 payment life.....	1,250
Ordinary life	740
20 year term.....	280

None of those policies really gives the best and cheapest solution to the problem. The answer is level-premium, decreasing term insurance.

That type of policy offers pure and simple protection. You must die for it to be effective, it has no cash surrender value and no loan value. Since it is decreasing term insurance, the face value gradually shrinks to nothing.

These policies may be bought under the name of "guaranteed income," "insured income" or "income protection." They run from five to fifty years in guaranteeing income to your beneficiaries.

Another way to accomplish the same thing is to take your ordinary life policy and get decreasing term coverage by having the basic contract extended.

Say you have a \$10,000 ordinary life policy. By adding a twenty year family income rider you can get about \$200 per month for your widow. If you should die within the next 20 years the company will pay her \$200 a month till 1976. Then the monthly payments will stop and the total of the original policy, \$10,000, is then paid to her. If you should live till 1976 or later, your widow will still get the \$10,000. Such a policy at age 35 totals about \$165 a year minus dividends.⁸ Don't forget that there is no small print on this like that found on the Social Security tax pensions.

To find out just what can be bought on the open insurance market, inquiries were sent asking premium figures for commercial insurance policies which would pay \$200 per month for 18 years at various ages. One, for instance, quoted the following:

Age 30.....	\$136.40	{ payable for 14 years only
35.....	\$164.00	
40.....	\$220.20	

If these figures are prorated over 18 years they become:

Age 30.....	\$109.00
35.....	131.00
40.....	176.00 ⁹

Remember also, no strings attached about remarriage, age of children, earnings, etc., as in Social Security tax pensions.

Let us take just one more way of showing how private insurance companies can run rings around Social Security tax pensions. Parenthetically, it can be said that in no form of enterprise can the government compete with private industry on the basis of lowest cost to the consumer.

Assumption: Doctors came under compulsory Social Security in middle of 1956. Social Security costs would be:

1956 (half year).....	\$ 63.00
1956-59 (\$126 per year).....	630.00
1960-64 (\$157.50 per year).....	787.50
1965-69 (\$189 per year).....	945.00
1970-74 (\$220.50 per year).....	1,102.50
1975	252.00

Total\$3,780.00

At this point Joe drops dead and the twins are 18. Now for insurance:

AGE	WHEN TWINS WERE BORN	TOTAL PREMIUM
25	(18 × \$92)	\$1,656
30	(18 × \$120)	2,160
35	(18 × \$164)	2,952 ³

SOCIALISM VERSUS INDEPENDENCE

It is a depressing commentary that today too few physicians take time to discern the mortifying effects of socialistic advances on our long respected individualism and pride of independence. There is a growing cult of "What's-In-It-For-Me" whose members react too quickly, too greedily, to material returns as opposed to spiritual growth and happiness within one's self.

The evils of the compulsory social insurance program were noted early by one man who, you might think, would be in favor of it. He was Samuel Gompers, president of the AFL from 1886-1924. Here are a few extracts of an address given by him on December 5, 1916:¹⁰

"There has never yet come down from any government any substantial improvement in the conditions of the masses of people, unless it found its own initiative in the mind, the heart and the courage of the people."

"Social insurance cannot even undertake to remove or prevent poverty. It is not fundamental and does not get at the causes of social injustice."

"For a mess of potage, under the pretense of compulsory social insurance, let us not voluntarily surrender the fundamental principles of liberty and freedom, the hope of the Republic of the United States, the leader and teacher to the world of the significance of this great anthem chorus of humanity—liberty."¹²

Gentlemen, compulsory Social Security is not for me. I hope you agree.

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BRIEF IN FAVOR OF SOCIAL SECURITY

A. R. FELTY, M.D., *Hartford**Doctors Voting in Favor of Social Security 507**Doctors Voting Against Social Security 76*

THESE were the final results of the Hartford County Medical Association referendum on Social Security conducted in September, 1956. Thus by a 7 to 1 vote, the physicians in one county of this State have unequivocally stated that they want Social Security. While these results may have jolted the faithful followers of organized medicine, they should in fact occasion no surprise, for when physicians take the time to learn the facts about Social Security, most of them will inevitably reach the same conclusions.

Here are the facts about Social Security. It has been established as the law of the land for 21 years (since 1935). At the present time about 70 million workers are covered by Social Security, in fact, *virtually all* employed and self-employed workers (including lawyers and dentists). But not ALL—for employees of organizations proved to be subversive are excluded by law, and about 200,000 self-employed physicians are excluded because of the opposition of the AMA.

The spokesmen of organized medicine, notably the Board of Trustees and the Bureau of Medical Economic Research of the AMA, have steadily attacked, both in print and before the Ways and Means Committee of the House of Representatives of the United States, the basic principles and financial benefits of Social Security. They have advanced three main arguments.

(1) Argument—Social Security is represented as the entering wedge for socialized medicine.

Answer—*Social Security for physicians has nothing whatsoever to do with socialized medicine.* Tens of millions of American workers have been covered by Social Security for years without the advent of socialized medicine. The inclusion of 200,000 physicians in the program will not change the underlying structure of the Social Security Act. When and if socialized medicine ever comes about in this country, it will be due to other causes, not to the fact that doctors have Social Security.

(2) Argument—The law is actuarially unsound. Retirement benefits are described as too generous

(*J. A. M. A.*, November 26, 1955, p. 1302). On the other hand, the price of survivors' insurance is declared exorbitant (*J. A. M. A.*, December 24, 1955, p. 1637). In an article in the *Journal A. M. A.* September 15-22, 1956, Drs. Webster and Coffey plunge boldly into a maze of actuarial intricacies to try to prove that Social Security is unsound, dishonest, and more expensive than regular insurance; and they even impugn the integrity of the duly elected members of Congress, and the honor of both political parties.

Answer—Actuarial soundness is a highly complicated matter which should be left to the actuarial experts. Our great life insurance companies accepted Social Security over twenty years ago. All their employees, including their presidents, their actuaries, and their medical directors are covered by Social Security. We do not hear them attacking the Social Security program.

However, since Drs. Webster and Coffey assailed the soundness of the program, their article has been analyzed by both government and life insurance actuaries, with this unanimous appraisal:—the premises on which Webster and Coffey base their arguments are fallacious, their reasoning is unsound, their conclusions are wholly erroneous and their prophecies are unjustified.

The charge made by Webster and Coffey that the cost of Social Security benefits exceeds that of ordinary insurance can be refuted by a study of the premium tables of any life insurance company. Furthermore, a careful cost study entitled "The Cost of Protection Comparable to Social Security" published in the *Bar Bulletin* of the Boston Bar Association, December, 1955 shows that the cost of Social Security is only one fourth to one half as much as insurance premiums, to obtain comparable benefits.

Perhaps the best answer is that of a very prominent and distinguished insurance actuary when he was asked recently for his opinion of Social Security. His answer was terse and pointed: "Get all you can of it!"

(3) Argument—The physician is pictured as a man who never retires before he is worn out. "At least 85 per cent of physicians between 65 and 72 years of age in the United States are in active practice. . . . It would not be good public policy to unduly encourage them to retire." (F. G. Dickinson, PH.D., director, Bureau of Medical Economic Research, AMA., *Bull. Essex County Med. Soc.*, N. J., March 1955, p. 167.)

Answer—It is a debatable point whether or not a doctor should continue to work until he is worn out. However, it is significant that the established practice of hospitals today is to *require* active staff members to retire from their posts at a definite age, usually between 62 and 65. Social Security does not require physicians to retire. It merely makes it easier for them to do so if they wish.

* * * *

From the many millions of employed and self-employed Americans who are covered by Social Security, including doctors employed by industry, hospitals, and medical organizations, we hear nothing to justify the arguments which have been used to block admission of the medical profession into the Social Security program.

The Congress of the United States is ready to legislate when physicians say they are ready to join.

Spokesmen representing the AMA stated during congressional hearings on the 1956 bill that physicians are willing to accept voluntary, but are opposed to compulsory coverage. It has been pointed out repeatedly that the Social Security statutes do not provide for voluntary coverage. (The single exception to this concerns the clergy, because the Congress is unwilling to legislate in respect to religious bodies.) It is wholly unlikely that the Congress will ever yield to a single group, the AMA, when all other self-employed groups of workers have compulsory coverage. Both the American Bar Association and the American Dental Association, which previously held out for voluntary Social Security, have now accepted the principle of compulsory coverage, and are now included in Social Security under the provisions of the 1956 bill.

In spite of the fact that the spokesmen of the AMA have attacked Social Security on the ground that it is actuarially unsound, they have not opposed *voluntary* coverage for physicians. But, as a matter of fact, *voluntary* coverage is actuarially unsound because it violates one of the basic principles of group insurance, namely inclusive coverage of

the entire group. Thus the stand of the AMA spokesmen is grossly inconsistent and contradictory.

The physicians in the country may choose between compulsory coverage or nothing. A referendum which asks the doctor whether he wants voluntary Social Security is unrealistic—it asks whether or not he wants something that does not exist. A referendum which asks the doctor whether he wants *compulsory* coverage is prejudicial. It is asking a "loaded" question, in using the word "compulsory" which is intended to arouse an instinctive prejudice. The word "compulsory" is redundant. The only question confronting the physician is whether or not he wants to be included in this program of old age benefits and survivors insurance.

Some spokesmen of the AMA wish a tax-deferment retirement program (as provided in the Jenkins-Keogh bills) in place of Social Security. Neither the 83rd nor the 84th Congress showed the slightest inclination to take up these measures. It is unlikely that future Congresses will either, until physicians are included with all other groups of workers in the Social Security program. Furthermore, the Jenkins-Keogh bills are not a substitute for, but a supplement to, Social Security. Discussion of the Jenkins-Keogh bills is simply not relevant to the subject of Social Security.

Many physicians have heretofore been opposed to Social Security without studying the provisions of the act.

Social Security provides retirement income to those over 65, and a basic security income to widows, children under 18, and certain other survivors. In addition, the 1956 law provides for those over 50 years old who are totally disabled.

A self-employed worker, earning annually \$4,200 or more, will now pay \$141.75 per year. This figure will gradually increase every five years until 1975, when the cost will be approximately \$265. Since most physicians earn \$4,200 a year, they would make these maximum payments and also receive these maximum benefits, as follows:

On retirement at 65, an individual physician would receive a monthly payment of \$108.50 and when his wife becomes 65, they would together receive \$162.80 a month—\$1,953.60 a year. (At age 62 his wife may elect to receive 75 per cent of the amount which would be payable at age 65). If he chooses to work after 65—to quote the brochure of the Social Security Administration October, 1956,

"No matter how much you earn in the year, benefit payments may be made for any month in which you neither worked for wages of more than \$80 nor rendered substantial services in self-employment." Thus if he chooses to take a vacation for four months, he will receive payments during that period. Moreover, a self-employed physician over 65 would not be regarded as rendering "substantial services" if he devoted to his patients as many as forty to fifty hours a month; thus he might continue to earn several hundred dollars a month, and still be entitled to retirement benefits. At age 72 he receives each month his full retirement income, irrespective of his earnings. Income derived from sources other than "earnings" (e.g., interest, dividends, annuities, etc.) does not affect benefit payments.

At his death his widow, if over 62, receives \$81.40 a month during her lifetime.

In case of his death at an earlier age, the law provides for his widow with two or more children \$200 a month until the children become 18. Payments are resumed when the widow becomes 62.

At death of the insured person at any age, a lump-sum payment of \$255 is paid to the surviving spouse.

Under the amended bill of 1956, the worker will receive monthly payments in the event of total disability after the age of 50.

In summary, the younger physician receives protection for his family in the event of his death. As he gets older he is protected in case of disability. At the retirement age of 65 he is privileged to receive a substantial monthly income as long as he lives, as does his widow who survives him.

Moreover, every benefit payment under Social Security is exempt from all taxation. In this unique respect it differs from almost every other form of income. In these days of high income taxes, this exemption provides very considerable savings.

The Board of Trustees of the AMA, in a statement regarding Social Security for physicians (*J. A. M. A.*, p. 1302, November 26, 1955), said, "Physicians as a group do not seek federal charity. . . . The argument that we should accept these windfall benefits because almost every eligible citizen will have little appeal to physicians. . . ." Others are more forthright and say they will not get aboard the "gravy train" with 70 million other Americans. Strangely enough, certain other opponents attack Social Security from the opposite direction. They

contend it is a vast government swindle—"a Ponzi type shell game." How the American people can ride a "gravy train" and get swindled at the same time is not very clear.

Obviously the Social Security program, the fruition of 21 years of careful study, is neither a hand-out nor a hold-up. It is, in fact, one of the great social movements of this century. The citizens of the United States have underwritten the Social Security program as truly as they have underwritten the national defense program. You as a citizen have participated in underwriting it. Whether you will participate in its benefits is up to you.

In making your decision, do not let misleading words such as "socialized medicine," "compulsory," "welfare state" and other scarehead phrases confuse the issue.

The issue is simple.

Do you want this protection for yourself and your family?

Think it over and then VOTE.

The Controversy Over Roentgenological Diagnosis of Lung Cancer

Frequently one hears of a patient with far advanced cancer of the lung coming to operation where the findings present a hopeless prognosis. When such patients have been repeatedly subjected to x-ray examinations, it raises a serious question in the minds of the general practitioner as well as the specialist as to just where the fault lies. From the City of Hope Hospital in the Far West comes the statement that failure to diagnose lung cancer is largely due to poor interpretation of roentgenograms and the cursory procedure undertaken. This particular writer emphasizes the need for reviewing old roentgenograms and for paying particular attention to minor changes in new pictures.

Another authority at the University of Pennsylvania does not belittle the need for better interpretation of roentgenograms but feels that an improvement in radiographic techniques is called for. Supervoltage roentgenography holds out the most promise today, although body-section technique serves much the same purpose.

Whatever is the answer, the need for a refinement in diagnosis exists and should command the attention and efforts of the leaders in this field.

BILLS INTRODUCED INTO THE 1957 GENERAL ASSEMBLY THAT RELATE TO HEALTH, WELFARE AND OTHER MATTERS OF INTEREST TO PHYSICIANS

This list is not complete because copies of all bills introduced were not available at the time this list was compiled

House Bills

HB3—Gustafson and D'Addario, R., Windsor. Concerning sale of milk in bottles. Would permit sale of milk in glass bottles by gallon and half-gallon and containers of a paper composition not to be reused. *Agriculture*.

HB32—Douglass, R., Greenwich. Concerning scholarship loans for students of medicine and dentistry. To aid Connecticut students in the study of medicine and dentistry and encourage them to practice in the state. Scholarships not to exceed \$500 for each of four professional college years without interest for ten years. Recipient shall be licensed and practicing in his state for three years. Similar bill in 1955 Assembly reported unfavorably. *Education*.

HB75—Paavola, R., Salisbury. Create a commission to investigate the establishment of a special institute for sexual deviates. Has been introduced many times before. *General Law*.

HB89—Mansfield, R., Preston, and Pallanck, R., Stafford Springs. Compulsory liability automobile insurance. Would require \$10,000 insurance for injury or death of one person, \$20,000 for injury or death of two or more persons and \$5,000 property damage to obtain motor vehicle license. Similar bills introduced frequently before and discarded. *General Law*.

HB126—Prokop, R., Stratford (by request). Concerning protection of physicians and patients. Identical with SB152.

HB159—Padula, R., Norwalk. Concerning distribution of polio vaccine and making an appropriation to the State Department of Health. Would provide for the free distribution of polio vaccine to all persons under the age of twenty years regardless of financial ability in order to protect more effectively the public health and safety. Amend Sec. 2046d and appropriate \$400,000 to the Department. *Public Health and Safety*.

HB162—Mrs. Prokop, R., Stratford. Concerning labelling of hazardous substances. *Public Health and Safety*.

HB163—Pepe, D., Derby. Authorizing investigation of the Griffin Hospital, Derby. *Public Health and Safety*.

HB165—Farmer, R., Darien. Concerning child day care centers. Empowers State Department of Health to license child day care centers. *Public Health and Safety*.

HB174—Sheehan, R., West Hartford. Provides for the state to pay employees' hospital insurance premiums. *Public Personnel*.

HB176—Wolcott, R., Granby. Would have state assume cost of hospitalization and medical service plans for state employees. *Public Personnel*.

HB183—Sheehan, R., West Hartford. Provides for the payment by the state for group medical and surgical in-

surance for state employees. *Public Personnel*.

HB191—Beatty, R., Roxbury. Provides relief for liability for cost of support in state humane institutions. Persons to be relieved of all indebtedness for support in state humane institution prior to July 1, 1955. *Public Welfare and Humane Institutions*. Sponsored by Legislative Council.

HB275—Mortensen, R., Newington. Concerning compulsory automobile liability insurance to insure payment of damages to person injured or damage to property as a result of the operation of motor vehicles. Similar bills introduced in previous sessions. *General Law*.

HB302—Cipriano, R., North Haven. Registration of sanitarians. Creates a State Board of Registration and Licensure for Sanitarians. *Judiciary*.

HB366—Curtis, R., Newtown. Concerning protection of physicians and patients. Identical with SB152. *Public Health and Safety*.

HB367—Koskoff, R., Plainville. Regulating use of title psychologist. Amends Sec. 4632 to 4638 of the Statutes relating to the Board of Examiners for psychologists and restricts the use of term psychologist to persons registered and licensed with the board. *Public Health and Safety*.

HB380—Mrs. Prokop, R., Stratford. Concerning rate of state payments to public health nursing agencies. Provides that the state shall pay public health and visiting nursing agencies on the basis of costs and public charges. *Public Welfare*.

HB382—Gocgel, D., New Britain. Creates a state commission on aging. To study problems of the aging with particular reference to employment, housing, recreation, education, health and economic security. *Public Welfare*.

HB383—Mrs. Cook, R., New Haven. Concerning adoption of children. Would give the State Welfare Commissioner increased supervision over adoption except by blood relations in order to eliminate the so-called black or gray market adoptions and to provide for filing of applications in the probate district of Hartford or the district in which an adoption agency is located when the child is being placed by the Welfare Department or such agency. *Public Welfare*.

HB384—D'Amicol, R., Bridgeport. Concerning the establishment of homes for elderly persons in State Mental Hospital. *Public Welfare*.

HB402—Turner, R., Bethany. Operation of motor vehicles while under the influence of intoxicating liquors or drugs. Would provide for presumptions or inducement of evidence in chemical tests in cases involving alleged operation of motor vehicle under the influence of alcohol or other drugs. *Transportation*.

HB438—Clarke, R., Stamford. Tax exemptions for certain

commissioned officers of the United State Public Health Service. Would allow tax exemptions in the amount of \$1,000 for commissioned officers who served in the United States Public Health Service between June 29, 1945 and December 31, 1947. Would put officers in the Public Health Service in the same tax exemption position as officers of the combat services during the period following World War II. *Finance*. Similar bill previously supported by Medical Society.

HB478—Prokop, R., Stratford. Control of sources of ionizing radiation. Would require all users of radioactive substances to register with the State Department of Health except use of x-rays for diagnostic or therapeutic purposes under the supervision of physicians, osteopaths, chiropodists, naturologists, dentists, chiropractors and veterinarians. *Public Health and Safety*.

HB479—Prokop, R., Stratford. Concerning district departments of health. Clarifies the tenure, compensation and duties of district boards of health and the term of office for board of health members. Also provides state financial assistance on a per capita basis and provides for withdrawal of towns from the district and provides civil service and retirement benefits for employees. *Public Health and Safety*.

HB482—Prokop, R., Stratford. Concerning distribution of biological products. Repeals emergency legislation for control of priority, supply and distribution of polio vaccine. Continues existing legislation authorizing the State Department of Health to procure biologic products for the free use of people of the state upon whom the purchase thereof would impose a financial hardship and to continue existing legislation authorizing regulations determining the priority of supply, distribution and use of biological products when epidemic exists and there is shortage of such biological products. *Public Health and Safety*. See HB159.

HB483—Mrs. Prokop, R., Stratford. Concerning reports of convictions of healing arts practitioners. Designates the documents needed by the State Department of Health and the Attorney General's office in carrying out sections of law providing for charges and hearings against physicians and other practitioners of the healing arts. *Public Health*.

HB498—Pepe, D., Derby. Providing for relief from liability for cost of support in state humane institutions. Identical with HB141. *Public Welfare*.

HB572—Cady, R., Kent. Dissemination of information concerning sale and prescription of contraceptives to married women. The "medical" birth control bill introduced every session. *Public Health and Safety*.

HB682—Cipriano, R., North Haven. Would amend Sec. 2103d so as to clarify its meaning and allow the courts discretion in making the penalties fit the offense and differentiate between persons who are the victims of the drug addiction and those who are profiting by the sale of drugs and promoting it. *General Law*.

HB690—Suarez, R., Cheshire. Would remove restrictions on advertising by dentists and dental laboratories in dental or dental trade journals. *Judiciary and Governmental Functions*.

HB694—Suarez, R., Cheshire. Increases payment of members of the Dental Commission (Dental Examination Board) from ten to twenty-five dollars per day; and the

salary of the recorder (secretary) of the Board, from \$2,500 to \$5,000 per year. *Judiciary and Governmental Functions*.

HB710—Curtis, R., Newtown. Amends Sec. 1510d to provide that licensing of inpatient psychiatric services in general hospitals shall be included in the provisions of Sec. 2051d under the general definition of "hospital." Also makes changes to legally formalize the State Attorney General's ruling on subject of persons suffering from harmless chronic mental illnesses. *Judiciary*.

HB730—LaFleur, D., Thompson. Labeling of hazardous substances. Similar to others. *Public Health and Safety*.

HB731—Pepe, R., Ansonia (by request). Would make available operating rooms in all non-profit hospitals and to all licensed members of the medical profession. Also available to the patients of the hospitals, the doctor of their choice. *Public Health and Safety*.

HB740—Curtis, R., Newtown. Would provide payment by the State of all committment fees and expenses for mentally ill and mentally defective persons instead of by the estate or relatives of the mentally ill persons. *Public Welfare*.

HB743—Clarke, R., Stamford. Would make permanent the \$18.75 per week maximum charge for support in institutions and eliminate the recapture clause under which legally liable relatives who have paid their obligations for the support of committed persons as billed by the state are yet liable for differences between charges paid and per capita costs. *Public Welfare*.

HB746—Curtis, R., Newtown. Would change the definition of mentally ill person to conform with the definition of a mentally ill person according to Sec. N786, Article II, paragraph F, of the Interstate Compact on Mental Health enacted by the General Assembly, November 1955. *Public Health*.

HB747—Curtis, R., Newtown. Provides for the attendance at meetings of the Commissioner of Mental Health at meeting of the Mental Health Council and provides representation of the Undercliff Hospital Board of Trustees on the Mental Health Council. *Public Health*.

HB752—Farmer, R., Darien. Appoints a commission of eleven persons to make a study of Connecticut's mental health laws and submit recommendations to the Governor and the general assembly for improvement. *Public Welfare*.

HB755—Curtis, R., Newtown. Would permit Undercliff Hospital to be included in legislation enabling institutions of the Department of Mental Health to accept and receive bequests and/or gifts. *Public Welfare*.

HB757—Curtis, R., Newtown. Permits participation of Undercliff Hospital and the superintendents of all the institutions of the Department of Mental Health. *Public Welfare and Humane Institutions*.

HB1003—Cook, R., New Haven. Removal of citizenship requirement for registration as a registered nurse or licensed practical nurse. General Assembly of 1955 waived citizenship requirements for applicants between June 2, 1955 and October 1, 1959. This bill would remove citizenship requirement permanently. *Judiciary and Governmental Functions*.

HB1007—Cleary, R., Middletown. Would extend for an additional year waiver of the requirement of a certificate from an approved institution for eligibility for examination

for licensure as a practical nurse. *Judiciary and Governmental Functions*.

HB1008—Cook, R., New Haven. Would establish that no person other than a "registered nurse" or "licensed practical nurse" shall assume or use the title "nurse" alone or in combination with any other word or words, and eliminate the practice of nursing and the use of the title "nurse" by unlicensed personnel and remove from the statute the controversial sentence "This Chapter shall not prohibit the care of the sick in their homes or by those who do not hold themselves out to be registered nurses or licensed practical nurses. *Judiciary and Governmental Functions*. Introduced as a result of the study of the Commission appointed by Mayor Lee of New Haven as an outcome of the "Jaspers" case in New Haven, August, 1956.

HB1032—Curtis, R., Newtown. To protect female mentally ill patients. Identical to SB377. *Judiciary and Governmental Functions*.

HB1061—Mrs. Prokop, R., Stratford. Concerning the labelling of Hazardous Substances. *Public Health and Safety*.

HB1062—Blackman and Eielson, R., Trumbull. Designates State Tuberculosis Commission as the state agency to administer and distribute state funds to be used for the control of tuberculosis within the state. Permits district departments of health or nonprofit corporations to apply to State Tuberculosis Commission for funds to be used to assist in establishing, maintaining or expanding services for control of tuberculosis within the state. *Public Health and Safety*.

HB1063—Prokop, R., Stratford. Refilling of prescriptions for dangerous drugs. Similar to SB153 and makes Sec. 3944 uniform with the Federal Food and Drug Act. *Public Health and Safety*.

HB1066—Bascom and McCartin, R., Waterford. Would permit the appointment of licensed veterinarians as municipal directors of health. *Public Health and Safety*.

HB1093—Mrs. Curtis, R., Newtown. Would establish a Department of Mental Retardation and a commission as distinguished from the department of mental health or the trustees of state institutions for the retarded so as to provide an overall program for the care of mentally deficient and retarded persons whether inmates of institutions or not. *Public Welfare and Humane Institutions*.

HB1094—Blackman and Eielson, R., Trumbull. Adds to emergency legislation passed in 1955 that would permit state institutions to employ physicians who are non-citizens by also permitting in emergency such institutions to employ nurses and technicians who are non-citizens. *Public Welfare and Humane Institutions*.

HB1100—Blackman and Eielson, R., Trumbull. Would utilize hospital beds in state sanatoria when such beds are not needed for the care and treatment of persons with tuberculosis for the treatment of persons with chronic diseases other than tuberculosis. Such chronic diseases are defined in this bill as those which require prolonged definitive hospital care in contrast to diseases or conditions which may be properly cared for in convalescent, custodial or domiciliary facilities. *Public Welfare and Humane Institutions*.

HB1107—Beatty, R., Roxbury. Would make persons in

medical institutions as a result of mental illness or tuberculosis ineligible to receive old age assistance since the federal law does not permit federal funds to be given to a state for such cases. *Public Welfare and Humane Institutions*.

HB1108—Beatty, R., Roxbury. Would limit expenditures for medical care of state supported beneficiaries to the fee schedule set by the Commissioner of Finance and control or charge to the general public, whichever is less. *Public Welfare and Humane Institutions*.

HB1170—Turner, R., Bethany. Would guarantee the discarding of the areas of the bodies of food animals which may be contaminated by the presence of implanted hormones or hormone-like substances. *Agriculture*.

HB1174—Turner, R., Bethany. Would protect the milk supply intended for human consumption from contamination by drugs and the products produced in diseased mammary glands of milk-producing animals. *Appropriations (Agriculture?)*.

HB1390—Winnick, R., Shelton. Whenever a private corporation shall be insured by a company licensed to operate in this state against loss to such private corporation because of torts of its agents or employees, such private corporation shall be liable for the torts of its agents and employees to the same extent as would be any person under similar circumstances not to exceed \$50,000 and its immunity from liability as a charitable institution shall no longer be a defense. *General Law*.

HB1395—Cairns, R., Madison. Repeals Sec. 4 of PL 324 of 1955 (2103d) and substitutes *or for (and)* so that a person convicted of violation of use of narcotics shall not be both fined and imprisoned. Corrects phraseology in 1955 act. *General Law*.

HB1448—Turner, R., Bethany. Amends law covering the practice of veterinary medicine, surgery and dentistry. Permits Connecticut Veterinary Medical Association to file one name of veterinarian practicing in this state recommended to be appointed to the Veterinary Examining Board. Otherwise amends law of Veterinary Practice Act to improve it. *Judiciary*.

HB1558—Mrs. Prokop, R., Stratford. Defines the profession of optometry as the employment of any means or methods other than the use of drugs or surgery for the purpose of examining the refractive condition of the human eye or any visual anomalies thereof; or the employment, adapting or prescribing of lenses, prisms, or other optical appliances and devices and corrective ocular exercises, orthoptics or visual training. Extends the definition of optometry to include the procedures named in the latter part of the bill. *Public Health and Safety*.

HB1559—Mrs. Prokop, R., Stratford. Changes the terms of members of the State Board of Examiners in Optometry from three years to five and empowers State Board to formulate, adopt and invest regulations not inconsistent with law. *Public Health and Safety*.

HB1560—Prokop, R., Stratford. Extends examining privileges of the Board of Examiners in Optometry to include in its examinations, in addition to subjects now listed in Sec. 4491, "Such other subjects as the Examining Board may deem necessary provided each applicant has been noti-

fied concerning the subjects in which he is to be examined." *Public Health and Safety*.

Senate Bills

SB9—Finney, 36, R., Cos Cob and Snyder, 7, R., Bloomfield. Concerning an appropriation for a medical and dental school. Provides the sum of \$500,000 to the Board of Trustees of the University of Connecticut to prepare and obtain plans and specifications for the construction of a medical and dental school and to purchase land for such purpose. Recommendation of 1955 Legislative Committee. Project previously approved by the State Medical Society. *Education*.

SB50—Bundock, 23, R., Bridgeport. Provides unemployment, sickness and disability compensation. Similar to other bills introduced previously and in this session. *Labor*.

SB60—Minnetto, 30, R., Goshen. Concerning the labelling of hazardous substances. To provide for the proper labelling of hazardous substances to prevent cases of accidental poisoning. Introduced by Advisory Committee on Foods and Drugs on which the Society is represented. Similar bill defeated in 1955, was supported by medical society. This bill sponsored by Legislative Council by agreement. *Public Health and Safety*.

SB72—Watson, 4, R., Wethersfield. Concerning support of patients in the Newington Home and School for Crippled Children. Would correct Sec. 1441d by adding language which would clearly indicate that the state's part in the amount of 25¢ is not in lieu of all other aggregate payments and is not in lieu of payments from private sources. No additional appropriation required. *Public Welfare and Humane Institutions*.

SB73—Watson, 4, R., Wethersfield. Concerning the cost of the education program of Newington Home and Hospital for Crippled Children. To clearly indicate that the state's part in the education and program at Newington shall include proper expenses applicable only to the hospital-school program by eliminating costs of operating the therapies personally authorized which although applying to schools in general are a proper charge to the cost of operating a children's school. *Public Welfare and Humane Institutions*.

SB74—Watson, 4, R., Wethersfield. Concerning reimbursement of Newington Home and Hospital by state for part of costs of hospitals approved educational program. Would permit State Board of Education to pay two-thirds of the annual costs of the hospital-school program of this institution, not exceeding \$600 per pupil. *Public Welfare and Humane Institutions*.

SB121—Squillo, 11, R., New Haven. Reports of state toxicological laboratories in evidence. Attendance of toxicologists at court is not necessary and costly since they are needed for laboratory work. Enactment of this bill would reduce such court attendance because testimony of state toxicologists would be required only if laboratory findings were challenged with expert testimony. *General Law*.

HB131—Scanlon, 6, New Britain. Concerning the establishment of nonoccupational disability benefits for certain employees. Would establish compensation for off-the-job injury and illness. Similar bills have been in previous Sessions. *Labor*.

SB133—Scanlon, 6, D., New Britain. Concerning unemployment sickness and disability compensation. Similar to HB131. Would provide money payments under Chapter 374 to an individual as compensation for his wage losses due to unemployment as a result of illness or other disability resulting in being unable to work due to illness or disability and shall include an allowance for dependents. Similar bill in previous session. *Labor*.

SB152—Marsilius, 25, R., Trumbull. Concerning the protection of physicians and patients. A mild euthanasia bill. Would protect physicians in the administration of drugs and in refraining from feeding and sustaining patients against their will. *Public Health*.

SB153—Squillo, 11, R., New Haven. Concerning the filling of oral prescriptions for certain narcotic drugs or compounds found to possess relatively little or no addiction liability. Would provide conformity with the Federal Narcotic Law to remove the requirement for written prescriptions for narcotic drugs which have little or no addiction liability; to facilitate the work of physicians and pharmacists and give better service to the public for emergency treatment of illness. *Public Health*.

SB194—Squillo, 11, R., New Haven. Concerning the establishment of a state poison information center. Would authorize State Department of Health to establish and maintain a poison information center to which hospitals and physicians could refer for information on the ingredients of substances which are potentially poisonous, and other information concerning physiological effects and antidotes. Poison centers are being developed in most states and are helpful in preventing death from ingestion of common household drugs and chemicals. This bill supported by pediatricians of Connecticut. Appropriates \$38,200. Referred to Committee on *Penal Institutions* by mistake because of uncertainty of word poison in title, was read to be "prison." Will be referred to *Public Health*.

SB258—Borden, 2, D., Hartford. Concerning definition of chiropractic. An amendment to Sec. 4381 defining chiropractic. This bill was developed in conference between representatives of the State Medical Society and State Chiropractic Association at request of and suggestion of Governor Ribicoff after he had vetoed a similar bill passed by Assembly in 1955, veto requested by State Medical Society.

SB315—Barringer, 32, R., New Milford. Appropriates \$50,000 for the preparation of plans and specifications for school of veterinary science at the University of Connecticut. There is no school of veterinary medicine in New England. Could be regional school and is strongly urged by many. *Education*.

SB377—Healey, 10, D., New Haven. Provides for protection of female patients escorted to state mental hospital because of possibility that deluded female patients may accuse male escorts of improper actions. *General Law*.

SB381—Drutman, 9, R., New Haven. Identical with SB630. Would admit published statements as evidence in cases of contract or tort for malpractice. *General Law*.

SB387—Drutman, 9, R., New Haven. Would eliminate the immunity from tort liability of charitable corporations, hospitals and institutions. *General Law*.

SB404—Drutman, 10, R., New Haven. Would amend Sec. 2597d of General Statutes so that medical service cor-

porations (CMS) could write insurance for medical, surgical, nursing, hospital and other services rendered or prescribed by doctors of medicine. Introduced by CMS to enable it to cover hospital insurance to be included in a contemplated major medical contract for subscribers. *Incorporations.*

SB409—Healey, 10, D., New Haven. Establishes qualifications and of superintendents of Undercliff Hospital now under jurisdiction of Department of Mental Health. *Judicial and Government Functions.*

SB439—DesRosiers, 29, R., Willimantic. Provides medical, nursing and hospital care for recipients of old age assistance by using all available resources for such hospital care including services of general hospitals, chronic and convalescent hospitals, as may be required. *Public Health and Safety.*

SB441—Healey, 10, D., New Haven. Definition of mentally ill persons. Changes definition of a mentally ill person to include each person afflicted by mental diseases to such an extent that he requires care and treatment for his own welfare or the welfare of others or the community. Brings definition into conformity with Inter-state Compact on Mental Health enacted by the General Assembly, special session of 1955. *Public Health and Safety.*

SB442—Healey, 10, D., New Haven. Provides for the attendance of the Commissioner of Mental Health at meeting of the Mental Health Council and provides the Commissioner with authority in keeping with responsibilities imposed upon him by this chapter and also provides for representatives of the Board of Trustees of Undercliff Hospital (new) on the Mental Health Council as is provided for representation from the Board of Trustees of other state hospitals. *Public Health and Safety.*

SB468—Healey, 10, D., New Haven. Would give greater medical character to the extended leave status of patients from state hospitals or state training schools to facilitate obtaining federal support for convalescent patients from state mental hospitals. *Public Welfare.*

SB476—Healey, 10, D., New Haven. To permit State Welfare Department to make authorized charges and collections for services to patients in Undercliff Hospital. *Public Welfare and Humane Institutions.*

SB482—Healey, 10, D., New Haven. Adds Undercliff Hospital to institutions to be represented on the Board of Trustees of the Department of Mental Health. *Public Welfare.*

SB484—Healey, 10, D., New Haven. Amends present law to permit Department of Mental Health to grant funds to general hospitals to establish and *maintain* psychiatric services. Act passed in 1955 omitted the word "maintain." *Public Health.*

SB480—Healey, 10, D., New Haven. Exempts members of the Council on Mental Health and trustees of Undercliff Hospital from personal liability in any civil action for damages on account of any official act or omission of any superintendent. Adds these persons to others so exempt, such as trustees of the Connecticut State Hospital, Norwich State Hospital, Fairfield State Hospital and Connecticut Child Study and Treatment Home. *Public Welfare and Humane Institutions.*

SB481—Healey, 10, D., New Haven. Adds Trustees of Undercliff Hospital and any member of the Council on Mental Health to list of persons to be represented by the Attorney General of the State of Connecticut in civil actions when acting in official capacity and provides that damages recovered in every such act shall be a proper charge against the general fund of the state. *Public Welfare.*

SB620—Sweeney, 14, R., Naugatuck. Would permit a court to appoint an impartial physician to give testimony in any action wherein the nature and extent of the injuries are in dispute. *General Law.*

SB628—Borden, 2, D., Hartford. Amends Sec. 3230d to provide for commencement of year of statute of limitations for injuries resulting in death "Where such injuries resulting in death, occurred by reason of malpractice or defective manufacture and/or inspection, the one year period following the neglect or fault complained of shall be deemed to commence when such neglect or fault was first discovered, or in the exercise of proper judgment should have been discovered. *General Law.*

SB630—Borden, 2, D., Hartford. Would admit as evidence in malpractice cases, against physicians, surgeons, dentists, optometrists and sanatoria, a statement of fact or opinion on a subject of science or art contained in it a proposed treatise, periodical, book or pamphlet in the discretion of the court if the court finds that it is relevant and that the writer of such statement is recognized in his position or called as an expert on the subject. *General Law.*

SB752—Bundock, 23, R., Bridgeport. Would compensate injured workers for time lost while undergoing medical treatments. *Labor.*

SB766—Scanlon, 6, D., New Britain. Would appoint a committee of qualified persons to study uses and means to avoid the disastrous financial effects of long term illnesses and to make recommendations concerning methods to avoid financial ruin of persons so effected or responsible for persons so effected. *Public Health.*

SB767—Bundock, 23, R., Bridgeport. Would create a Catastrophic Illness Fund to protect all persons in the state against the disaster of a catastrophic illness which would use up their financial resources and disrupt family life, and make it possible for doctors and hospitals to give required medical care with an assurance of payment in catastrophic illness. No appropriation is included in the Bill. Has been before the General Assembly frequently in the past. *Public Health and Safety.*

SB771—Squillo, 11, R., New Haven (by request). Would provide "adulteration" of public water supplies. Provides a fine of not less than \$250 nor more than \$1,000 or imprisonment for not less than six months nor more than one year for any person, firm or corporation, public or private, or for any official having control and management of potable water supplies to add to any public water supply, any substance excepting that which is necessary to enhance the safety and potability of the water. (common, would prohibit flouridation). *Public Health and Safety.*

SB786—Finney, 36, R., Cos Cob. Creates a commission to study codification and revision of laws pertaining to the State Welfare Department. *Public Welfare and Humane Institutions.*

SB914—Borden, 2, D., Hartford. In all actions for the recovery the recovery of damages for personal injuries, now pending, or which shall hereafter be brought, if the attending physician or physicians have died prior to the time of trial of said action, the written reports of said doctor or doctors to the patient, or to the legal representative of such patient, shall be admissible as a business entry when offered by any party in the trial of said action. *General Law.*

SB938—Borden, 2, D., Hartford. Relates to medical reports in compensation cases. Amends Sec. 3041d by adding "The Employee or his Attorney, as well as the Employer and his insurer or attorney, shall furnish each other, upon written request, copies of all medical reports of all doctors who have attended or examined the employee in connection with injury claimed to have been sustained the employee would facilitate the handling of compensation claims by making all medical information available to all parties. *Labor.*

HB1065—Prokop, R., Stratford. Illegal possession of dangerous drugs. Repeals first sentence of Section 3931, Section 2 and rewrites as follows: "No person shall manufacture, possess, have under his control, sell, prescribe, administer, dispense or compound any drug covered by Sec. 1589(c) of the 1953 supplement to the General Statutes, except as authorized in this chapter." *Public Health and Safety.*

HB1096—Suarez, R., Cheshire. Concerning sale of medicine to epileptics and the furnishing of the same to persons receiving state aid. Provides that the State Department of Health shall upon application of any epileptic person who presents the prescription of any duly licensed physician therefore, obtain such medicines as are therein prescribed and sell the to such person at the cost of the state thereof. If patient is receiving state aid under chapter 130 or 131, the drug shall be procured by the Welfare Commission in cooperation with the State Department of Health.

OUR NEIGHBORS

New York

The Medical Society of the State of New York recently cabled \$5,000 to the American Medical Society of Vienna for aid to Hungarian refugees.

Group Health Insurance, Inc., of New York has written the Kings County Medical Society, and the letter has appeared in the latter's *Bulletin*, to the effect that it will pay for treatment of the sick or injured to physicians instead of patients "when extra money is unavoidably available." This means that if a patient is covered two or possibly more times by the same or different insurance companies he might be paid his fee twice or even three or four times.

Although Group Health Insurance tries to dis-

courage double coverage, it is not always possible to detect this. It believes it is fairer to make double payment to the physician than to profit by withholding one payment or by making one half payment to the subscriber and one half to the physician. The latter would be contrary to the basic function of nonprofit insurance.

Vermont

The Vermont Medical Society reports that one County Society reimburses its Councilor ten dollars every time he attends a Council meeting. In return the County Society expect a report from him at each County meeting.

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

Recent Meetings

Mrs. William Horton, chairman of Publicity, held a Luncheon Meeting, January 28, at the New Haven Lawn Club to discuss plans for the remainder of the year. Present were Dr. Creighton Barker; Mrs. E. Roland Hill, president; Mrs. Paul W. Tisher, president-elect; Mrs. Creighton Barker; Mrs. F. Erwin Tracy; and Mr. James Burch, Public Relations director.

Mrs. E. Roland Hill, president; Mrs. Paul W. Tisher, president-elect; and Mrs. Dewey Katz, chairman Public Relations attended a meeting of the Connecticut Health League, Wednesday, January 30 in New Haven.

Mrs. Alfred B. Sundquist, Finance chairman, held a meeting of her committee, February 12, at 160 St. Ronan Street, New Haven, to prepare the budget for 1957-58. Members present were Mrs. E. Roland Hill, president; Mrs. Paul W. Tisher, president-elect; Mrs. J. Alfred Wilson; Mrs. William Horton; and Mrs. Edwin Connors.

Dates to Remember

May 1, 1957, Annual Meeting, 10:30 A. M., Hartford Golf Club.

June 3-7, 1957, 34th Annual Convention Woman's Auxiliary to AMA, Hotel Roosevelt, New York City.

Make your reservations now!

NEWS FROM WASHINGTON

New Legislation in 85th Congress

NATIONAL HEALTH INSURANCE AGAIN PROPOSED

One of the original sponsors of the 14 year old health insurance proposal and the son of another cosponsor have introduced identical bills on the subject in the House and Senate. The measures are S844 by Senator Murray (D—Montana) and HR 3764 by Rep. Dingell (D—Michigan). They differ from the original Murray-Wagner-Dingell bill only in their scope. Because some sections have since been enacted into law piecemeal, the 1957 version is minus these features: education of health personnel, medical research, Hill-Burton expansion, aid to rural and shortage areas, more State grants for health work, and grants for maternal and child health.

The bill provides a contributory system of health insurance covering the working population similar to social security. A separate bill to be introduced later would charge workers 1½ per cent of earnings or up to \$90 a year, with employer contributing an equal amount. The money would go into the U. S. Treasury under a Personal Health Services Account separate from social security but with the Social Security Administration running the program. Covered workers and their families would be eligible for preventive and diagnostic exams, lab and x-ray services, hospitalization up to 60 days, dental services, more expensive drugs, special appliances and eye glasses. With the government authorized to ask Congress for added funds, total cost (exclusive of medical public assistance) might be \$10 billion.

HOSPITALS

Interest in federal hospital programs is reflected in a number of newly introduced bills. Rep. Poage (D—Texas) proposes in HR1979 to authorize \$50 million from which the Secretary of Health, Education, and Welfare could make loans for construction of nonprofit hospitals; this was offered at request of a hospital that is opposed to federal grants (which it would be eligible for under Hill-Burton), but instead wants a loan.

Senator Mundt (R—South Dakota) is proposing in S230 that the present Hill-Burton law be changed to allow a grant to nonprofit diagnostic treatment

centers even if they are not connected with a non-profit hospital, a requirement in present Hill-Burton law. However, the center would have to be one receiving operating help from a State or State subdivision.

VETERANS

Any combat veteran awarded the Purple Heart would be deemed to be 10 per cent disabled from service connected causes under a bill (HR330) by Rep. McDonough (R—California). This disability rating would be in addition to any other disability rating VA had established for the veteran. The effect would be to make every Purple Heart winner a service connected case for purposes of medical care; the "availability of space" restriction and "cannot afford to pay" oath would not apply to him, and he would be entitled to home-town as well as hospital care.

Rep. Henderson (R—Ohio) proposes a three year "presumptive" period of service connection for arthritis, psychoses and multiple sclerosis, as well as tuberculosis. The presumptive period of arthritis is now one year, for psychosis and multiple sclerosis, two years. The bill is HR1143.

DRUGS AND DRUG CONTROL

Food and Drug Administration often finds it difficult to establish that a shipment of barbiturates or amphetamines is in interstate commerce and therefore under control of the federal government. Rep. Byrnes (HR503) would solve the problem by having Congress declare that the regulation of interstate commerce in barbiturates and amphetamines is essential to the effective regulation of their interstate commerce. Also, manufacturers, compounders and processors would have to comply with specific registration and record keeping regulations, but physicians and "all other legitimate handlers of the drugs" would not. Similar bills are HR1073 and 504 by Rep. Boggs (D—Louisiana).

Rep. Multer (D—New York) is introducing a bill that evoked some attention in the last Congress. The new number is HR825. It would authorize the President under certain circumstances to proclaim it necessary for U. S. to regulate the use, distribution, and price of vaccine, serum, medicine, chemi-

cal or other substance intended for use in the prevention or treatment of disease. Violators would face a maximum \$10,000 fine or a year in prison or both. Either the President or Congress could declare the particular emergency at an end and remove the federal government from the field.

MILITARY

To assist in the procurement of physicians and other technically and scientifically trained personnel for the military services, the three secretaries would be authorized to establish scholarships, in a bill by Rep. Bennett (D-Florida). Its number is HR560. Payments would cover living expenses, tuition, library and laboratory fees, books, material, etc. For each \$1,000 of scholarship money the recipient would be under obligation for an extra year of federal service (in addition to draft obligation), which time could be served on military duty or as civilian Defense Department employees in certain fields. If discharged before completion of obligated time, recipient would have to repay the government for money spent, with interest. Persons on active military duty could be granted leave of absence without pay to benefit from the scholarships, but the stipend could not exceed \$110 per month. Mr. Bennett also has a somewhat similar bill (HR564), but under this plan the applicant would have to agree to serve three years on active duty for each year in which he received federal help, but for a maximum of four years. A third Bennett bill (HR1055) would establish a United States Armed Forces Medical Academy. The Secretary of Defense would be responsible for constructing and equipping the project and for setting standards of eligibility. Cadets to be appointed by members of Congress, the President and the Secretary of Defense, could not number more than 600 at any one time. Actual vacancies would be filled by competitive examinations among the nominees. Emphasis would be on the military and civil defense subjects, but otherwise the curricula requirements would be the same as for accredited medical schools. Graduates would be required to serve five years on active duty, and following that to remain liable for an additional three years' active duty as reserve officers at the discretion of the Secretary of Defense. However, if he practiced in an area designated by the Surgeon General of PHS as a "doctor shortage area," the physician would be exempted from the additional three years.

TAX DEFERMENTS

Identical bills by Reps. Jenkins (HR9) and Keogh (HR10) would permit the self employed, including physicians, to annually deduct from adjusted gross income as much as 10 per cent of net earnings or \$5,000, whichever is the lesser, when paid into retirement plans. Total set aside allowed during a taxpayer's lifetime could not exceed \$100,000; unused allowances could be carried over from earlier years. For persons between age 50 and 70, an additional 10 per cent of net earnings for each year of age over 50 would be allowed. Another change from previous Jenkins-Keogh proposals is a provision to allow cash surrender before age 65 upon payment of a tax penalty.

Provision is made in the bills for reporting to the Bureau of Internal Revenue by banks and insurance companies so that tax authorities can keep track of persons claiming deductions.

Others have introduced variants of Jenkins-Keogh proposals. Rep. Coudert's HR45 would allow up to 5 per cent of net earnings, or \$3,000, whichever is the lesser; and his HR43 would allow up to 10 per cent of taxpayers' adjusted gross income. Rep. Keating's bill is HR251, and Rep. Ray's, HR380.

Rep. Tom Curtis has sponsored a measure (HR129) permitting deduction of medical expenses without regard to the present \$10,000 maximum ceiling for a large family, and Mr. Keating, a bill (HR286) that would allow sliding scale deductions based on income directly from income taxes of money paid for hospital and medical insurance.

TAXES AND SOCIAL SECURITY

Senator Langer (R-North Dakota) wants the starting age for disability payments under social security (now 50) eliminated altogether. Also, he would eliminate a provision of the present law that reduces OASI payments to the extent the beneficiary also is receiving money under other government programs, such as VA or workmen's compensation. Senator Langer's bill is S173. Such an effort to reduce or eliminate the age at which a disabled person can receive OASI payments was forecast last session when the disability program was enacted. Rep. Multer (D-New York) in HR808 would waive income taxes on certain expenses incurred by taxpayer for the education of a dependent, these expenses to be in addition to the present \$600 overall deduction allowed for dependents. Rep. Mc-

Donough (R-California) recommends (in HR1186) that taxpayers be given a three year period to which they may "carry over" medical expense deductions that exceed the present maximums permitted for each year.

Under HR1192, also by McDonough, a taxpayer would be permitted to deduct his payments for health insurance coverage (to a maximum of \$200 per year) from taxable income, even though his total health expenses do not exceed 3 per cent of his taxable income. Under present law, only medical expenses deductible are those in excess of 3 per cent. To qualify for the new deduction, health plans would have to meet certain requirements.

Rep. Tom Curtis has sponsored a bill (HR131) that would authorize a waiver of social security taxes and benefits for persons participating in private insurance or retirement plans. Under it, benefits of the private plan would have to be determined by the secretary of HEW to be at least equal to Old Age and Survivors Insurance benefits to which the individual would be entitled. Further, the cash surrender value of the private plan would have to equal the payroll taxes that would have been paid to OASI. Finally, if the person stopped participating in a plan, he would have to pay into the OASI fund the tax that otherwise he would have had to pay.

AGING

Bills to handle problems of the aged were among the most popular at the opening. One group of bills would set up fact-finding commissions, and another would establish a Bureau of Older Persons in the Department of HEW. Rep. Coudert would create a 25 man Commission on Programs for the Aging (HR44) which would include 14 Presidential appointees.

They would study, investigate and hold hearings on (1) problems growing from the increased proportion of older persons and (2) remedial measures including but not restricted to care and services in the home, use of foster home facilities, recreation centers, and provision of institutional facilities for the chronically ill. It would report to the President.

Rep. Ostertag (HR373) would provide for a 12 man commission which would study and report to Congress on such things as (1) physical and mental aspects of aging, (2) employment of the aging, (3) public and private retirement programs and policies, (4) housing for older persons, and (5) recreational programs for the aging.

Rep. Rhodes in his bill (HR383) would establish a Bureau of Older Persons in HEW and would authorize \$2 million to States developing certain plans for the aged. Each State would get not less than \$10,000, and up to one third of actual expenditures for studies and projects. Another \$500,000 would be authorized for similar programs being developed by public and other nonprofit institutions and organizations; maximum grant for any one institution would be \$30,000. State plans would, among other things, have to provide for consultation with voluntary organizations in this field.

A select House committee and a short-term commission are proposed to study problems of the aging. Senator Potter (R-Michigan) in S258 recommends a U. S. Commission on Aging and Aged, to be made up of 10 members from Senate and House, the executive branch and private life. It would study aged persons' problems in employment, income maintenance, health and physical care, housing, living arrangements, recreation. The commission's recommendations would be made to Congress prior to July 1, 1958, at which time it would disband. The Select House Committee proposed by Rep. Yates (D-Illinois) in H.Res.61 would be composed of seven members, and be assigned to (a) investigate problems of the aged, (b) determine what the federal government's responsibilities are in regard to the aged, and (c) determine how the U. S. can best cooperate with local communities and private industry to improve conditions for the aged. It would be advised to complete a report as soon as practicable. Rep. Kelley (D-Pennsylvania) would use an existing House committee, that on Education and Labor, to make a study of the problems of the aged and report its findings to the House as soon as practicable. His measure is H.Res.78.

Rep. Celler (D-New York) in HR1092 is reintroducing an old idea, first advanced by Oscar Ewing when he was administrator of the Federal Security Agency (now HEW). It provides a maximum of 60 days free hospitalization for persons covered by OASI who are 65 years of age or older. Included would be nursing, laboratory and ambulance service, drugs and operating room expense, but not the cost of surgery or medical care, except that generally furnished by hospitals. Also excluded would be tuberculosis and mental patients and those needing only domiciliary or nursing care. Rep. Yates (D-Illinois) in HR495 joins the growing ranks of legislators proposing federal grants for studies and projects on the problems of the aged.

VETERANS ADMINISTRATION

Bills designed to broaden veterans' benefits continue to occupy the attention of many members of Congress. Rep. Kearney (R-New York) proposes in HR701 to amend VA laws to give priority in hospital care to combat veterans or veterans who have served overseas. If they so qualify, they would take precedence over all other nonservice connected cases, but would not outrank veterans with service connected disabilities.

Rep. Rogers (R-Massachusetts) has three bills that would expand veterans' medical care benefits. HR917 provides that a veteran with nonservice connected active pulmonary tuberculosis be deemed to be permanently and totally disabled for pension purposes while he is hospitalized. In such cases pension payments now start only after attempts at rehabilitation have been made for six months or more. The other Rogers bills, HR929 and 924, would increase from two to three years the period after separation when multiple sclerosis and psychoses and malignant tumors would be presumed to be service connected if disabling to 10 per cent or more. Present law sets the limit at two years for the first two and one for tumors.

Chairman Teague (D-Texas) of the House Veterans Affairs Committee has sponsored a bill (HR58) tightening up admission procedures of veterans seeking VA hospitalization for nonservice connected disabilities. Present law permits hospitalization for such disabilities on a space available basis when the veteran states he is unable to defray necessary medical expenses. The head of the VA now has the right to prescribe any type of admission form; Mr. Teague's bill would set down specific requirements.

The veteran would have to declare: (1) extent of any medical, surgical, hospitalization or health insurance and all annuities of which he is a beneficiary, (2) all insurance policies on his life, (3) value of all real or personal property owned by him, (4) average monthly income during preceding six months, (5) average monthly expenditures, and (6) his net worth. The bill then provides that after reviewing these points with the veteran, the admission officer will read to the veteran the laws and the criminal code having to do with fines for making false affidavits or statements.

Most important, the VA official would estimate the length of hospital stay, and if under 30 days would estimate the cost of treatment in private facil-

ities. This would guide the veteran in deciding whether he can "afford" to pay.

Mr. Teague also has sponsored bills (1) consolidating into one act and making more uniform veterans laws on compensation, pension, hospitalization and burial benefits (HR53), (2) simplifying and making more nearly uniform laws on compensation for service connected disability or death (HR54), and (3) consolidating all laws on hospital and domiciliary care and treatment, and acquisition and operation of such facilities (HR57). None of these proposals would enlarge present benefits.

Mrs. Rogers, ranking minority member of Veteran Affairs Committee, has introduced a number of bills broadening or establishing presumption of service connection for certain diseases: HR413 for leprosy, HR415 for chronic and tropical diseases, and HR420 for malignant tumors.

FEDERAL EMPLOYEE HEALTH INSURANCE

The most important bill so far introduced in this Congress regarding federal employee health insurance is one by Rep. Lesinski (D-Michigan) that is sponsored by a federal employees' union. Its essential provisions: The U. S. would pay 50 per cent of the cost of basic or catastrophic health insurance for civilian employees and their spouses and children under 19 years; there would be payroll deductions for the employee's share of premiums; if an employee retires on an annuity after 15 years, the U. S. pays entire cost of premium. An administration bill is expected to be introduced later.

PUBLIC HEALTH

Rep. Lane would authorize unspecified amounts of money to help States on matching basis to maintain and increase enrollment of schools of nursing and to provide nursing scholarships (HR306). The Surgeon General of PHS, who would administer the program, would be authorized to make a minimum grant of \$200,000 to each State.

Under a bill by Rep. Judd (HR246), the PHS surgeon general would be authorized to conduct surveys as to the need for domestic and community facilities, and to develop projects for their construction among the Indian population.

Connecticut Congressmen on Senate and House Committees

In the roster of Senate and House committees of the 85th Congress, Connecticut is represented as

follows: Senate Committee on Labor and Welfare, William A. Purtell; Senate Committee on Armed Services, Prescott Bush; House Armed Services Committee, James T. Patterson; House Ways and Means Committee, Antoni N. Sadlak; House Government Operations Committee, Edwin H. May, Jr.; House Post Office and Civil Service Committee, Albert W. Cretella.

Eisenhower Budget Asks Increases for Health-Medical Programs

The Eisenhower administration's budget, presented to Congress on January 16, calls for a large number of moderate increases in federal health-medical programs, and for a few sharp boosts. While funds asked for research are designed only to maintain the present programs (for which appropriations were doubled last year), relatively large increases were asked for Food and Drug Administration activities, for promotion of work on chronic disease and health of the aged, for both air and water pollution control and for improving health of American Indians. The overall budget of the Department of Health, Education, and Welfare would be increased about 23 per cent to \$3,070,602,412 and that of the Public Health Service 6.5 per cent to \$576,730,000. Some of the items:

MEDICAL, DENTAL EDUCATION

Although not a part of the budget, the administration will ask \$15 million for the first year of a proposed program of construction and equipment grants to help medical, dental and osteopathy schools build and equip teaching facilities.

FOOD AND DRUG ADMINISTRATION

The increase would be from \$7.9 million to \$10.5 million, to allow for stricter enforcement of food and drug laws and to provide for more scientific research in new food and drug problems. Another objective is to reduce the backlog of pending new-drug applications.

OFFICE OF VOCATIONAL REHABILITATION

The ultimate goal is 200,000 rehabilitations annually, next year's aim is 90,000. An increase of something over \$7 million would bring the agency's appropriation to \$50.9 million.

CHRONIC DISEASE, HEALTH OF AGED

The increase asked for "to improve the community services for the chronically ill, especially

older persons," is about 400 per cent for a total of \$2.7 million. Of this \$1.5 million would go for special projects to be conducted by public or non-profit agencies and \$1.2 for technical assistance and research. Improved home care, clinics, restorative and rehabilitation services and various types of studies are planned.

HILL-BURTON HOSPITAL GRANTS

A total of 121 million is asked, a reduction of \$4.2 million; the "old" program is cut \$12.8 million, but the "new" program is upped \$9 million. The \$1.2 million for research would be continued.

AIR, WATER POLLUTION CONTROL

For air pollution control a 50 per cent increase is asked, for a total of \$4.1 million; for water pollution control the increase would be 57 per cent, to \$53 million, most of which will go for construction grants.

HEALTH SERVICES, TRAINING

For general health grants to States, mostly to stimulate development of better local public health programs, the amount would be upped 50 per cent, to \$15 million. Funds to help in postgraduate public health training would be increased from \$1 million to \$2 million, and professional nurse training money would go from \$3 million to \$4 million.

INDIAN HEALTH

While only about a 10 per cent increase is asked for general Indian health services, the administration also is asking \$5.8 million for clinics and hospital renovation and \$4.8 million for basic sanitation facilities for Indians and Alaskan natives.

Senator Bricker Introduces a New Treaty Amendment

Senator Bricker (R-Ohio) is renewing his efforts to protect domestic law against possible encroachment by treaties. He has presented a new version of a constitutional amendment, an earlier version of which was defeated in the Senate by a one vote margin in 1954. Although Senator Bricker conferred with President Eisenhower before offering the new resolution, he did not indicate whether he had won the President over to the new provisions. It was largely through opposition of the President that the earlier proposal was defeated. The AMA supports the Bricker amendment in principle. The new version reads:

Section 1. A provision of a treaty or other international agreement not made in pursuance of this Constitution shall have no force or effect. This section shall not apply to treaties made prior to the effective date of this Constitution.

Section 2. A treaty or other international agreement shall have legislative effect within the United States as a law thereof only through legislation, except to the extent that the Senate shall provide affirmatively, in its resolution advising and consenting to a treaty, that the treaty shall have legislative effect.

Section 3. An international agreement other than a treaty shall have legislative effect within the United States as a law thereof only through legislation valid in the absence of such an international agreement.

Section 4. On the question of advising and consenting to a treaty, the vote shall be determined by Yeas and Nays, and the names of the Senators voting for and against shall be entered on the Journal of the Senate.

Revenue Bureau Rules on Extra Work by Residents

Internal Revenue Service has issued a ruling (No. 57-21) which holds that a hospital resident who fills an extra job with fixed hours and pay is an employee twice over for Federal employment tax purposes. In case at issue, the resident gave four hours weekly to surveillance and treatment of an organization's physically handicapped workers, for which he received a flat monthly salary. IRS ruling points out that his activities are directed and controlled by employer, hence he is an employee for purposes of wage withholding and other Federal obligations.

"Physicians and other individuals engaged in the pursuit of an independent trade, business or profession, in which they offer their services to the public, are independent contractors and not employees," the ruling states, in part. "However, if the requisite relationship exists between a physician and another, he is an employee rather than an independent contractor with respect to any services performed under such circumstances. One of the major factors to be considered in determining the existence of an employment relationship is the right of direction and control."

Heart Research Grant to AHA Official

Public Health Service has announced the largest research grant of its kind ever made by the National Heart Institute. A total of \$575,000 has been awarded Alan E. Treloar, Ph.D., director of research for the American Hospital Association. Its purpose: to evaluate the effectiveness of drugs in treating heart disease. Dr. Treloar formerly was with the University of Chicago as a statistician and economist. The initial study will be concerned with hypertension. PHS Surgeon General Burney: "A large scale clinical study such as this is needed to evaluate as rapidly as possible new forms of treatment developing in the heart field. . . . The AHA study will provide a testing program for these drugs and others as they are developed, on a scale not heretofore possible. Its result will be of wide interest and will help provide information that we do not now have as to the most effective drugs or combination of drugs. . . ."

AEC Awards \$750,000 in Medical Research Grants

Atomic Energy Commission has approved 59 more research grants in life sciences, of which 34 are in medicine. In latter category, the five new projects and 29 renewals will get total of approximately \$750,000. Dr. Shields Warren's radiation injury program at New England Deaconess Hospital, Boston, will receive \$205,000 of this sum. Lovelace Foundation at Albuquerque, New Mexico, gets \$75,000 for study of indirect blast injuries, and Worcester Foundation in Shrewsbury, Massachusetts, gets \$56,760 for support of its radiation studies. Remaining 31 grants are all under \$50,000. Eighteen of the nonmedical awards are in biology, six in biophysics and one in radiation instrumentation.

Cortisone Lotions Held to Prescription Usage

Food and Drug Administration published an order in *Federal Register* recently which denies petitions supporting over-the-counter sale of ointments and lotions containing hydrocortisone and hydrocortisone acetate. Its action was based on evidence taken at hearings here last August. Several experts held it would be impracticable to write adequate directions for self medication in treatment of skin

conditions and warned that protracted use of hydrocortisone compounds by laymen might be dangerous. Ten pharmaceutical firms had petitioned for exemption from the existing prescription-only requirement.

Health Insurance Firm Cited in Order by FTC

Federal Trade Commission has ordered Travelers Health Association of Omaha, to stop making advertising claims for its health and accident policies which FTC claims to be false. In reaching a unanimous decision, commission members were not divided—as they were in American Hospital & Life Insurance case last April—as to Federal jurisdiction over interstate advertising of health insurance. Chairman John W. Gwynne who, in that case, was member of minority which held that U. S. lacked jurisdiction, wrote a separate opinion here in which he held that the Omaha firm's challenged advertising was subject to Federal regulation because it was carried on solely by mail and sent into some States in which Travelers was not licensed.

The Commission also disclosed issuance of orders by hearing examiners which prohibit misleading advertising by two other companies in health insurance field: Federal Life & Casualty Co., Battle Creek, Michigan and Reserve Life Insurance Co., of Dallas. These are not final decisions and may be appealed, stayed or docketed for review.

Federal Trade Commission, in a 3-1 decision, has directed Craftsman Insurance Co., Boston to stop false advertising of health and accident benefits. This is tenth cease and desist order of FTC, out of 41 complaints issued against insurance companies since October, 1954, with 12 cases in the initial findings stage, one in Federal court and 18 still in hearing stages.

Food and Drug Administration has taken under advisement recommendations by an expert panel that over-counter sale of vitamin A compounds be prohibited when daily dosage is in excess of 50,000 units and that drug firms be encouraged to package liquid A in small, calibrated containers minimizing chances of overdosage, particularly to children.

Rise of Medical Care Costs Most Consistent

January issue of *Economic Indicators*, a statistical report published monthly by Joint Congressional Economic Committee, contains a table on consumer

prices which puts medical care in a unique light. For it discloses that the cost index for this category (including hospitalization and drugs, as well as medical services) has gone upward without interruption since 1939—a distinction that cannot be claimed by housing, food, recreation, transportation or any other consumer item. Still the increase in medical care costs between 1939 and November, 1956 is not as great percentagewise as the price rise for food, apparel, transportation or personal care, in the same span of years.

Navy Doubles Residency Program

Recent figures compiled by the Navy show that its residency training program has more than doubled in the last two years. In January, 1955 training in 19 specialties was being received by 150 Navy physicians. A year later the total was 204, and this month it is 335. The two most popular specialties are obstetrics and gynecology and internal medicine, with 54 doctors now in residencies in the former and 53 in the latter.

THE DOCTOR'S OFFICE

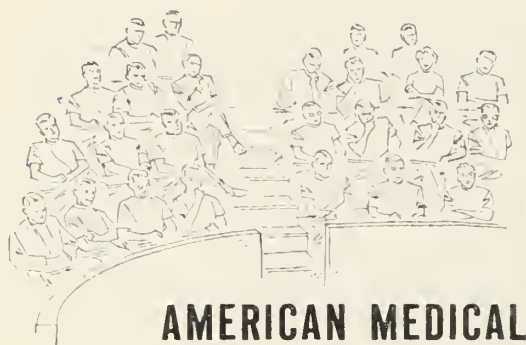
William Lynch, M.D. announces the opening of an office for the practice of internal medicine at 40 North Street, Milford.

Donald F. Rayl, M.D. announces the opening of an office for the practice of general and thoracic surgery in Putnam.

Frederick Van Poznak, M.D. announces the opening of an office for the practice of general surgery at 147 Main Street, Ridgefield.

Tuberculosis Not Licked Yet

The National Tuberculosis Association has reported the following TB statistics: more than 15,000 people die annually of the disease, despite the decline in death rate; 11 States and the District of Columbia had an increase in death rate in 1955 as compared with 1954; nearly 80,000 new active cases are being reported annually; in people over 65 years of age, one death is reported for every two cases; infection is taking place, in some parts of the country, at the rate of one person per 100 population a year.



AMERICAN MEDICAL



EDUCATION FOUNDATION

Connecticut Committee

160 ST. RONAN STREET
NEW HAVEN 11, CONN.

THE 1957 CAMPAIGN FOR MEDICAL EDUCATION

The 1957 AMEF Campaign to help American medical schools will start soon.

The campaign will be conducted in Connecticut by the AMEF committees of county medical associations.

Contributions may be earmarked for any approved American medical school. Every dollar goes to the school because administrative costs are paid by the American Medical Association. Also, contributions may be deducted from income tax.

Active county campaigns last year made Connecticut the sixth leading AMEF state. California, New York, Pennsylvania, Illinois and Minnesota were the only states with better records.

This generous support by physicians in all parts of the state is gratefully acknowledged. Your continued support in 1957 will keep Connecticut in a leading place.

Wm G. H. Dobbs
Chairman

Committee Members

William G. H. Dobbs, M.D. • G. Robert Downie, M.D. • Louis O. LaBella, M.D. • Milton M. Lieberthal M. D.
Charles E. Jacobson, Jr., M.D. • Orvan W. Hess, M.D. • Paul J. Gerity, M.D. • Marjorie A. Purnell, M.D.
Meryvn H. Little, M.D.

SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

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Associate Member

Connecticut a Leading State in 1956 AMEF Campaign

Connecticut was the seventh leading state in the number of physicians who contributed to the 1956 campaign of the American Medical Education Foundation and ninth leading state in the amount of contributions, according to a recent report.

A total of \$20,795 was contributed by 916 Connecticut physicians, as compared to 334 contributions totaling \$9,658 in 1955.

The national 1956 AMEF campaign brought a total of \$534,075 in contributions from physicians; \$216,623 from medical associations and allied organizations; \$90,989 from the Woman's Auxiliary and other groups; and \$225,000 from the American Medical Association. The grand total for the national campaign was \$1,072,727 representing a 41 per cent increase over the previous year.

The Connecticut campaign was conducted by AMEF committees in each county medical association. Hartford County took first place, with \$5,937 raised from 268 contributors, while 146 Fairfield County physicians contributed \$2,640 and \$1,489 was contributed by 66 physicians in New Haven County. Other county campaigns produced the following results: Litchfield County, \$850, 27 contributors; Middlesex County, \$515, 17 contributors; Windham County, \$260, 6 contributors; New London County, \$190, 7 contributors and Tolland County, \$155, 9 contributors.

Dr. William G. H. Dobbs, Torrington, was chairman of the state committee for the campaign and the chairmen who directed the county association campaigns were Charles E. Jacobson, Jr., Hartford and Manchester, Hartford County; Milton M. Lieberthal, Bridgeport, Fairfield County; Orvan W. Hess, New Haven, New Haven County; G. Robert Downie, Winsted, Litchfield County; Louis O. LaBella, Middletown, Middlesex County; Mervyn H. Little, Willimantic, Windham County; Paul J.

Gerity, New London, New London County; and Marjorie A. Purnell, Vernon, Tolland County.

Popular AMA Health Magazine for Physicians' Offices

Today's Health, published by the American Medical Association, is finding its way into the reception rooms of more and more physicians' offices.

The Woman's Auxiliary of the State Medical Society, as part of a leading national program is actively engaged again this year in obtaining subscriptions for the use of this authentic health publication in professional offices.

Mrs. Dewey Katz, Hartford, Regional AMA chairman for *Today's Health*, has explained that physicians may subscribe to the magazine at half the usual rate, \$4 for four years; \$3.25 for three years, or \$1.50 for one year.

In return for this small sum a collection of authoritative articles on health care becomes available every thirty days. In the February issue of the magazine, for example, there are articles on health care written by seven physicians and a number of articles authored by experienced writers in other fields. The magazine, formerly known as *Hygeia*, has been changed in format and brightened with color and helpful illustrations. Dr. W. W. Bauer, director of the Bureau of Health Education, American Medical Association, is editor of the publication and Dr. D. Austin Smith, editor of the *Journal of the American Medical Association* is a member of the editorial board. A sample copy of the magazine may be obtained by writing to the State Medical Society.

Meriden Medical Society Sponsors Health Forums

A series of four health forums was recently sponsored by the Meriden Medical Society for residents in that community.

The forums were held on Tuesday evenings in the high school auditorium in cooperation with the Adult Education Department of the Meriden Schools and the Y.W.C.A.

Program topics included emotional and psychological problems of adults and children, the preventive aspects of modern care, physician-patient relationships and the relationship of hospitals to patients and their families.

Information Program Valuable Part of Emergency Plan

A continuing information program is producing favorable results for the emergency call plan operated by the Lower Naugatuck Valley Medical Association.

Exhibits, leaflets and other communications media have been used to implement regular newspaper accounts of the community service. One of the features of the program is a newspaper announcement every thirty days by Dr. Ralph H. Edson, president of the association. In these announcements the names of all physicians who will be on emergency panels during the month are announced. The statement also contains information concerning operation of the plan and a reminder to residents that the plan should be used only in real emergencies.

The program keeps residents aware of the interest of local physicians in community service and the value of medical association activities. The emergency plan was started last year and serves the towns of Ansonia, Derby, Shelton, Seymour and Oxford.

Medical Education Week April 21-27

The public relations committees of all county medical associations have been requested by the American Medical Association to develop local plans for the observance of Medical Education Week, April 21-27. The event will mark the second annual observance of the contributions of medical education to American living. The general purpose of the week's activities will be to develop understanding of the aims, problems and progress of medical education. While this should result in more adequate support of medical education, the observance will not include any direct appeal for funds.

A number of national television programs will observe Medical Education Week and a program of

national scope is also being planned for newspaper, radio and magazine adaptation.

The sponsoring organizations comprise the American Medical Association, the Association of American Medical Colleges, the Student American Medical Association, National Fund for Medical Education and the American Medical Education Foundation.

National TV Documentary Scheduled for March 5

The March of Medicine television series will repeat the one hour documentary, "Monganga," which met with overwhelming response when first presented last November.

Depicting the daily rounds of Dr. John Ross, a medical missionary in the Belgian Congo, the production is scheduled for its second showing on the National Broadcasting Company network Tuesday, March 5, at 9:30 P. M., E. S. T.

"Monganga," tribal dialect for "white doctor," will be narrated by John Gunther, author of "Inside Africa." The March of Medicine series is produced in cooperation with the American Medical Association by Smith, Kline, French Laboratories.

Medical Students Return to Small Towns to Practice

A recent American Medical Association report says that medical students who were born and raised in small communities usually go back to small towns to practice after their graduation.

Also, the report says graduates whose prior residence was in the smaller communities are less liable to limit their practice to a specialty.

The publicly supported schools—State or municipal—draw a higher proportion of their students from smaller communities and consequently contribute comparatively more physicians to the smaller communities than do the private schools.

AMA COMMITTEE ON MATERNAL AND CHILD CARE

March 30-31 in Philadelphia for the New England and Middle Atlantic States. Group will consider proposed guides for perinatal death studies similar to those prepared for maternal death studies.

OBITUARIES

Ashley Webster Oughterson, M.D.

1895 - 1956



Ashley Webster Oughterson was born of Scottish forbears in Seneca, New York on September 28, 1895. He received his early education in Geneva, New York and graduated from the Harvard Medical School in 1924. He continued his medical education at the Brigham Hospital in Boston where he was on the staff of Dr. Harvey Cushing, and later served at the Bellevue Hospital in New York City. In the early 30's he came to Yale as a Harvey Cushing Memorial Fellow in the Department of Surgery. From then until his entry into the Army in 1942 he was on the full-time surgical staff of the Yale University School of Medicine.

Using a surgical technique he learned under Dr. Cushing's guidance, he concentrated first on vascular surgery and later on the surgery of neoplasms. His chief interest was in the field of cancer until he left New Haven in 1956. A stimulating teacher and

loyal friend to his medical colleagues, he was consulted far and wide because of his extreme devotion to the individual problems of his patients. Beyond his care of their specific diseases he always sought out personal information which would help him in directing the patient back to a useful life in the community. With a keen sense of clinical research he would always review his past experience and change his therapy according to clinical results. The Tumor Clinic at the New Haven Hospital was developed under his wise and understanding guidance and records of his work attest to his superb attention to all details of individual patient care. His wise counsel to medical students and younger members of the surgical staff did much during those years to make postgraduate surgical training at Yale so outstanding.

In 1942 he helped to organize, and he left New Haven with, the 39th General Army Hospital assigned to the Pacific Theater. His vast experience was soon recognized by Army authorities and he was made Senior Surgical Consultant under General MacArthur. He traveled extensively to the Army hospitals in the area and served as chairman of the joint Army-Navy and Manhattan project to investigate the medical aspects of atomic bomb casualties at Hiroshima and Nagasaki. He landed in Japan a few days after the second bomb was dropped and quickly recognized the research possibilities of the many casualties. With Dr. Shields Warren of Harvard he wrote a formal report which is a classic description of bomb injuries. This magnificent piece of work culminated in a volume published by McGraw-Hill in 1956 under the title "Medical Effects of the Atomic Bomb in Japan." For his distinguished service he was awarded the Legion of Merit Medal with oak leaf cluster.

Scotty had many other interests. The economic aspects of the practice of medicine received his attention and he was keenly interested in the means of procuring for our citizens the best medical service possible. He was instrumental in getting a law passed in Connecticut to allow doctors to incorporate. This was a far seeing adventure but one that has not been taken up with much enthusiasm throughout the State.

Upon his return from the war in 1946, Scotty joined the staff of the American Cancer Society. In close cooperation with his old friend, Cornelius P. Rhoads, M.D., he strove with great vigor to bring the cancer problem to the attention of the American people. In addition to his many scientific papers with co-authors, including Grover Powers, Samuel C. Harvey, Willard Soper, David Cheever, John R. Paul and Harold M. Marvin, he wrote for the lay press to arouse the public to do more for cancer.

After his work with the Cancer Society he returned to New Haven and started a private surgical practice in an office shared by his wife, Marion Howard, who practiced internal medicine. At their attractive home in Woodbridge friends were always welcome and although he was not blessed with any children, all who knew him were under the spell of his jovial personality and his profound knowledge, which he always imparted with the utmost geniality. He continued teaching at the Yale School of Medicine and at tumor conferences one can never forget the quiet calm and intense concern with which he probed deep into every aspect of the patient under consideration. Follow-up care was as important as the operation and from this his many patients will continue to have the benefit. He took great pains to have the referring physician completely advised of the patient's total clinical history. When he left New Haven he made a special effort to forward his records to physicians who would be later responsible for each patient's care.

In 1956, a great opportunity for further service to humanity came to our beloved Scotty. Private practice was never completely to his liking and he was anxious to lend his great knowledge to further teaching and training of young surgeons. The Rockefeller Foundation appointed him to a post in Columbia, South America, where he was to help the medical schools in that country to improve their residency training program. On his 61st birthday, September 28, 1956, he and his wife sailed to Columbia to take up their new work. In the short time that he was there he had already made some fast friends and was well on his way for the new task which he had set before him. Six weeks after his arrival, on November 18, 1956, he was killed in an airplane accident in Columbia enroute from Bonaventuria to Cali. His sudden and untimely death was a great shock to a host of personal friends and to the medical profession to which he devoted and gave his life.

Norton Canfield, M.D.

Harry St. Clair Reynolds, M.D.

1880 - 1956



On Thursday afternoon, July 19, 1956, Dr. Harry St. Clair Reynolds suddenly died while playing cards with his family and friends.

Dr. Reynolds was directly a Yankee, his maternal grandmother being Nancy Edwards, a direct descendant of Jonathan Edwards, and his paternal grandfather, Henry Reynolds, was owner of one of the first gun factories in Connecticut.

Dr. Reynolds graduated *cum laude* from Yale Medical School in 1910. He was married in Colchester, Connecticut, June 27, 1912, to Miss Mabel M. Coughlin. There were two sons, William V. and Henry Bradley Reynolds, and seven grandchildren.

Dr. Reynolds did postgraduate work at the Polyclinic Hospital in New York as well as at the Baby's Hospital and Knapp Memorial Hospital.

He was a former instructor of pediatrics and of ophthalmology in Yale School of Medicine.

Dr. Reynolds formerly was attending physician in pediatrics at New Haven Hospital; associate attending in pediatrics at Grace Hospital, New Haven; attending Babies' Emergency Home, New Haven; and visiting attending physician to Hartford Hospital.

Immediately prior to his retirement, Dr. Reynolds was head of the eye department, Institute of Living, in Hartford and head of the eye department in the Connecticut State Prison.

He was a member of the American Medical Association, Connecticut State Medical Society, Hartford County Medical Association, and Fellow of New York Academy of Medicine.

He was the author of "Diet and Care of Children," "Ocular Etiology," and various other articles.

William B. Smith, M.D.

Veterans Medical Care Resolution

At the House of Delegates session in November, 1956, two resolutions were adopted concerning the present practice of the Veterans Administration in providing medical care to veterans with nonservice connected disabilities who are covered by workmen's compensation or who have private medical insurance.

The portion of these resolutions dealing with workmen's compensation is particularly interesting and has been the subject of comment in the past by the AMA Law Department.

In the cases in question the Veterans Administration has rendered treatment to injured veteran workers who are entitled to medical care without charge under state or federal workmen's compensation laws.

The basic federal law which provides for medical care for veterans is Public Law No. 2, 73rd Congress, as amended. Section 6 of this law provides that a "veteran who is in need of hospitalization . . . and is unable to defray the necessary expenses thereof . . . shall be furnished necessary hospitalization . . . in any Veterans Administration facility within the limitation existing in such facilities irrespective of whether the disability was due to service. The statement under oath of the applicant on such form as may be prescribed by the Administrator shall be accepted as sufficient evidence of inability to defray necessary expenses."

The question has logically been asked whether a veterans hospital should admit a compensation claimant for treatment of a nonservice connected disability when he is not personally liable for the cost of such medical care. It seems obvious that the federal statute is intended to limit hospitalization benefits in nonservice connected cases to indigent veterans who must look to governmental or private charity for such services. When the veteran involved is not required to pay for hospitalization

because he is entitled to such services by law (workmen's compensation claims), irrespective of his financial ability, then he should not be eligible for federal medical care.

Obviously, Congress intended to provide hospitalization to veterans with nonservice connected disabilities in a manner similar to the services offered by private charities. The workmen's compensation claimant is not in need of charity, and, therefore, a hospital administrator who provides medical care, having knowledge of such fact, may be violating the law.

Readers who know of any such instances of veterans' hospitalization are asked to notify the secretary of the American Medical Association.

Second New England Rural Health Conference Planned for Concord April 25

The Second New England Rural Health Conference will be held in Concord, New Hampshire, Thursday, April 25.

Sponsored by the American Medical Association, the conference is being planned by a committee of physicians, and representatives from farm and community organizations throughout the New England States.

Dr. Norman Gardner, East Hampton, chairman of the committee and regional director of the AMA Council on Rural Health, has announced the preliminary program for the one day Concord conference.

Registration is scheduled for 9:30 A. M. and the morning program will comprise the following presentations: "How Our Doctor Came to Our Town," a report from a New Hampshire community; "What We Did to Get Our Doctor," a report from another rural community; and "Why I Like to be a Country Doctor," a report by a rural physician.

Following luncheon, the afternoon session will be devoted to the aspects of prepayment medical and surgical care plans of particular interest to rural residents and a panel discussion, "Health in Later Years," with a physician, a nurse, a social worker and a selectman of a rural community as panelists.

Aubrey D. Gates, secretary of the AMA Council on Rural Health, will present a summary of the conference at the conclusion of the program.

FROM OUR EXCHANGES

Brennan in a brief discussion of "The Emergency Treatment of Acute Urinary Retention" divides the causative factors into two main groups: (1) obstructive, comprising prostatic enlargement and urethral strictures; (2) neurogenic, comprising neurologic disorders and inability to urinate following surgical procedures (*Miss. Valley Med. Jour.*, 78:4, pp. 175-176).

The most common cause of acute retention is prostatic enlargement. To relieve the situation it is necessary to use a curved metal catheter or a soft Foley catheter on a stilette. Undue force is not necessary. Suprapubic cystotomy is seldom necessary. Urethral stricture can generally be relieved by passing a small filiform or whalebone catheter. Sometimes it is necessary to work a long time before the stricture is finally bypassed. However, if one has patience and the supply of filiforms is adequate, successful passage is usually accomplished. Once the instrument is successfully passed, the preferred procedure is not to remove it but to leave it in place.

Retention after surgical procedures commonly can be relieved with the regular No. 20 catheter. Here it may be proper to stimulate the parasympathetics with Urocholine, Doryl or Furmethide. This is a temporary situation and will relieve itself in time.

Acute retention of urine following brain or spinal cord injury may be handled in three ways: (1) suprapubic cystotomy, (2) insertion of Foley catheter, and (3) allowing the bladder to distend and overflow. These patients generally have many problems with many of their organs and not only with the bladder.

* * * *

Holloway *et al* state that the mortality rate of staphylococcus sepsis has not been greatly reduced by the introduction of the antibiotics (*Delaware State Med. Jour.*, 28:7, pp. 151-155). Spink is quoted as recommending: (1) isolation and identification of offending organism prior to treatment, (2) surgical drainage of all suppurative and necrotic tissues and cavities; (3) treatment with a combination of antibiotics pending report of vitro sensitivities; (4) aggressive and persistent treatment.

The authors on the basis of their studies suggest the use of combinations of antibiotics. The antibiotics of choice should be selected individually for each case, depending on in vitro studies. Surgical and supportive treatment suitable for infections should be carried out. The thesis of the study is supported by three illustrative cases of staphylococcus sepsis, two of which cases recovered.

* * * *

Kay and Cross discuss "The Present Status of Carcinoma of the Lung" (*Ohio State Med. Jour.*, 52:3, pp. 240-254). As a result of educational efforts in behalf of this disease, patients are seen in the earlier stages of their disease (32 per cent resectability rate today as compared with 7.5 per cent 10 years ago). The curability of patients operated in the early phase of their disease is evidenced by the 70 per cent survival rate following therapeutic resection.

Few patients present a clear cut picture early in the disease. The persistence or exacerbation of an irritative cough may be the first and only sign and symptom of cancer and not the result of a cold or smoking. Dyspnea and wheezing may be caused by a partial bronchial occlusion as well as by asthma. Bronchopneumonia or unresolved pneumonia may be the result of malignant bronchial obstruction, atelectasis and infection. The presence of cavitation may be due to a necrotizing carcinoma or an abscess distal to an obstructed bronchus and not due to tuberculosis. These possibilities must be kept in mind as we go about the business of recommending further diagnostic procedures. Continued efforts should be made for the early detection of bronchogenic carcinoma.

* * * *

Bryan's "Report of a Case of Myasthenia Gravis" is chiefly interesting from the standpoint that he administered an average daily dose of 2,415 mg. neostigmine and 8,940 mg. pyridostigmin bromide for one year without serious toxic reactions (*Jour. Ind. State Med. Soc.*, 49:3, pp. 257-258).

* * * *

Head calls attention to the necessity of a reevaluation of artificial pneumothorax in the treatment of pulmonary tuberculosis (*Quart. Bull. Northwestern*

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SEARLE

Univ., 30:1, pp. 14-15). According to the author all treatment of tuberculosis at the present time is experimental. This is due to the fact that there has not been time to evaluate the results of prolonged combined drug therapy, and, furthermore, there has not been time to evaluate the results of lung resection.

Experience teaches us that most of the cases which are now being treated by resection would have remained well without surgery. It has been demonstrated that under the influence of prolonged combined drug therapy, many cavities are becoming completely or partially epithelialized without being closed. This fact suggests that if the walls of cavities can be held together by pneumothorax or by this treatment followed by phrenic nerve block and pneumoperitoneum, firm healing will take place in a relatively short time.

It seems probable that the pleural complications of artificial pneumothorax, which was the chief reason for discarding it, will be rare when the patient is on drugs. It seems reasonable to suppose that pneumothorax continued for a year and followed by a phrenic nerve block will be effective in a larger measure than it was formerly when continued for four years.

* * * *

Fink in a discussion of "The Practical Uses of Radioactive Isotopes for Diagnosis" considers only those uses that are of immediate clinical value as opposed to a research level (*Amer. Geriatrics Soc.*, LV:2, pp. 138-141). It is a question which many doctors have asked and Fink answers them briefly as follows.

Radioactive isotopes can be used to measure thyroid function, determine fluid space, measure circulation time, test the patency of circulation, localize tumors and metastases, and to furnish data in metabolic studies. It is predicted that many tests now being conducted on a research level will become clinically adaptable in the future. It appears that this comparatively new tool of diagnosis and treatment already has many values of immediate clinical usefulness.

* * * *

Thompson calls attention to obstruction of the vesical neck in children as a nearly forgotten cause of nonobstructive pyelonephritis or recurrent infection of the urinary tract in young children. Twenty one per cent of 387 pediatric patients referred to

the author for urological examination were found to have obstruction of the vesical neck. With one exception these obstructions were of a minimal nature with negative pyelographic studies. Such minimal obstructions in children are important clinical pathologic states and may be the answer to the so-called nonobstructive pyelonephritis of the young adult. Symptomatology is almost invariably referable to the urinary tract, except for abdominal pain and unexplained fever. Treatment in the majority of cases will lead to the amelioration of the symptoms.

The Early Bird Catches the Worm

The Sears-Roebuck Foundation announces that applications for financial assistance to physicians desiring to enter private practice are currently being processed for the first half of 1957. The deadline for receiving applications is April 1, with final determination on who will receive assistance no later than June 15. All applications are received by a 17 member Medical Advisory Board who use as the sole criteria for loan evaluation the medical need of the community and the financial need of the physician.

The Foundation makes an annual grant of \$125,000 to a revolving assistance fund for the purpose of making supplemental, 10 year, unsecured loans to physicians interested in establishing or improving facilities in suburban, rural or small town communities. These loans can be used for new building construction, remodeling, purchase of equipment, and for supplemental expenses connected with establishing a practice. The interest rate of these loans range from zero to six per cent depending on the rapidity of repayment.

This is an ideal time for graduating interns and residents who are interested in entering private practice but lack the necessary funds to apply since, if chosen, the funds will be available upon graduation in July. A Foundation spokesman urged all interested physicians to apply immediately and not wait for the April 1 deadline to insure proper processing of applications. Applications may be obtained from county or state medical societies, AMA's Council on Medical Service, or from the Sears-Roebuck Foundation, 3333 West Arthington, Chicago, Illinois.

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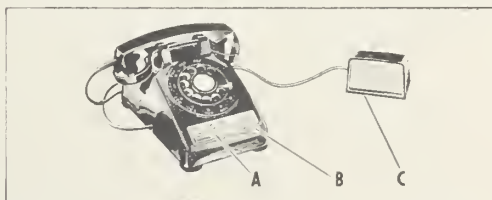


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AROUND THE STATE

Heart Disease and Retirement

A professor of rural sociology and a research assistant in rural sociology at the University of Connecticut have published a 36 page pamphlet under the title "Heart Disease and Retirement in the Hartford Standard Metropolitan Area." The research on which this report is based was financed by a grant from the Hartford Heart Association and reviewed by three physicians from its Board of Directors, Marvin D. Day, William J. Lahey and Paul H. Twaddle. Believing that our readers will be interested in this project we quote the Summary in full.

"The aging of the population and the emergence of retirement as an accepted pattern of behavior have given emphasis to programs for pre-retirement counseling. Health maintenance and an understanding of some of the diseases prevalent among the older population are often neglected in pre-retirement preparation, yet good health is a vital asset in the retirement years. Heart disease can be a threat to a successful retirement life, particularly if the persons affected are blindly afraid of the disease and its consequences and are unaware of the favorable adjustments that other retired persons with heart disease have made. The results of the research may help to dispel these fears and illustrate some of the consequences of heart disease, both favorable and unfavorable.

"Over 750 retired persons in the Hartford Standard Metropolitan Area were interviewed and detailed schedules of information were obtained from all retired persons with heart disease and from an equal number without heart disease. The incidence of heart disease for the retired men in this sample was 216 per thousand. The sample did not include persons who were in institutions, and no attempt was made to trace retired persons who had left the area. If these had been included, the rate of heart disease presumably would be higher.

"An understanding of the characteristics of men with heart disease will be of help in devising and administering a pre-retirement counseling program. Most of these men are married. Most of them have not had a high school education. All major occupations and broad nativity groupings are represented among the heart patients. All towns in the Hartford

Standard Metropolitan Area have one or more retired men with heart disease and East Hartford has a significantly larger incidence of heart disease among its retired population.

"In most instances the adjustment to retirement by men with heart disease has paralleled the adjustment of men without this affliction. Only a few found other forms of work following their retirement. Most of them suffered a substantial loss of income and had to make corresponding shifts in their expenditures. The most prevalent reductions in expenditures were for recreation, clothing, organizations and transportation. Practically none of the retired men were able to reduce their medical expenses. These expenses were especially severe for the heart patients, over one-fifth of whom indicated that more than ten per cent of their budget was allocated to medical services.

"Very few of the retired men with heart disease live alone or with nonrelatives. There is some evidence that for retired men with families a smaller proportion of the men with heart disease are living with their children than is the case for men without heart disease.

"Many men experience a decline in leisure time activities after they retire. The activity scores of men with heart disease are slightly lower than those of men who do not have heart disease. However, heart disease does not preclude social participation. Some heart patients participated in all of the activities that were surveyed and many men with heart disease have made an outstanding adjustment. Apparently, personal motivation buttressed by previous experience is a deciding factor in determining the use that is made of leisure time."

Connecticut Surgeons Elect

E. Cotton Rawls of Stamford was elected president of the Connecticut Society of American Board of Surgeons at the annual meeting held in New Haven, December 13, 1956. The new vice president is Bliss Clark of New Britain and the new secretary-treasurer, Eugene Fitzpatrick of New Haven. The principal speaker at the meeting was John D. Stewart, president of the American Board of Surgeons and professor of surgery at the University of Buf-

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by A. C. Fay, Ph.D., Director of Research

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The generally accepted standards indicate that good orange juice should contain 40 mgms. of Vitamin C per 100 cc of juice. Regular daily tests of each shipment of Hood Pure Orange Juice have shown that the product consistently contains from 55 to 65 mgms. per 100 cc as delivered to the customer. In no case has Hood Orange Juice fallen below accepted standards and commonly shows 25% to 50% more than the accepted standard of 40 mgms. per 100 cc.

It is apparent from the table below that a daily 6-ounce glass of Hood Orange Juice will satisfy most normal requirements—except during pregnancy and nursing periods, when 8 to 10 ounces of Hood Orange Juice should be drunk.

Classification	Daily Vitamin C requirement, as recommended by The Nutrition Board of The National Research Council	Fluid ounces of Hood Orange Juice needed to meet daily Vitamin C requirement
155 pound man	75 (mgms.)	5.1
124 pound woman	70	4.7
Pregnant woman	100	6.75
Nursing mother	150	10.2
School-age child	60-75	5.1

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The Vitamin C content—and the flavor—of Florida oranges varies widely from orange to orange. Often oranges from the top of the tree are richer in flavor and vitamins than those from the lower branches. Research indicates that Vitamin C content of oranges from the same tree may vary as much as 100%! Since Hood Orange Juice is a blend of the juice of thousands of Vitamin C rich, tree-ripened oranges, it is safe to assume that in many cases it will surpass home-squeezed oranges in both flavor and vitamins. In addition, home-squeezed juice is considerably more costly than the Hood product.

falo. J. Forbes Rogers of Stamford read a paper during the scientific section of the meeting.

Art Exhibit at State Society Meeting

Members of the Connecticut State Medical Society, their wives and children will be given an opportunity to exhibit their works of art at the new East Hartford High School, 777 Burnside Avenue, East Hartford on April 30, May 1 and May 2, inclusive.

Oil, water color, tempera, pastel, black and white, etchings, photography, sculpture and ceramics are eligible. All art exhibits will be received by a committee at the High School one day only, Sunday, April 28, from 10 A. M. to 2 P. M. The committee will be staging the exhibit in the afternoon so all art exhibits must be delivered uncrated by the artist or his agent to the entry committee at East Hartford High School before 2 P. M. Pictures should be suitably framed and wired for hanging. Copies may be entered but must be so labeled.

There is a fee of one dollar for each exhibit. Children's exhibits will be free. No exhibit may be removed until 4 P. M. on May 2 and must be removed by 6 P. M.

Each County Chairman or her representative will check to see that all exhibits from her respective county have left the gallery.

Members who wish to exhibit may contact the following chairmen:

Dr. John Freiheit, 85 Grove Street, Waterbury, chairman, Connecticut Physicians Art Association.

Mrs. Ralph T. Ogden, 15 Thicket Lane, Sunset Farm, West Hartford, chairman, Art Committee, Woman's Auxiliary to the Connecticut State Medical Society.

Mrs. Halsey Bullen, Hillcrest Park, Stamford.

Mrs. Ernest Rosenthal, 17 Pine Road, West Hartford.

Mrs. Thomas Danaher, 445 Prospect Street, Torrington.

Mrs. Vincent Vinci, Randolph Road, Middletown.

Mrs. Elliott Brand, 145 Cleveland Road, New Haven.

Mrs. Tage Nielson, 571 Ocean Avenue, New London.

Mrs. Robert Bowen, South Coventry.

Mrs. Lewis Giffen, 28 Chapman Road, West Hartford.

Judges will be appointed from among persons

prominent in Connecticut professional artist groups. Their names will be announced later.

Physicians who win awards will have their winning pieces exhibited at the AMA meeting in the New York City Coliseum in June at the expense of the Connecticut Physicians Art Association.

Fairfield County

Frederick C. Warring, Jr., assistant superintendent of Laurel Heights Sanatorium and associate clinical professor of medicine at Yale, was one of the Participating Faculty at the postgraduate course on Pulmonary Function sponsored by the American Trudeau Society held in Boston, March 25-29, 1957.

The Annual meeting of the Fairfield County Medical Association is to be held at the Stratfield Hotel, Bridgeport, Tuesday, April 9, starting at 4 P. M. An indoctrination session for new members is planned for Wednesday, April 3 also at the Stratfield Hotel.

The Mullins golf trophy, in competition at each semi-annual meeting, was formally presented to the winner, Ralph D. Padula, at a meeting of the Norwalk Medical Society recently. Making the presentation was J. Donald Corridon, president of the Fairfield County Medical Association.

The Greenwich Medical Society in February provided a group of its members to administer polio vaccine to students of the public school system there. More than 1,000 were inoculated at that time.

Hartford County

Hartford Hospital lost one of its most ardent and devoted workers in the sudden death of Philip G. McLellan on January 22. Dr. McLellan had held almost every position in the Hartford Hospital that a surgeon could hold. He served several terms as chairman of the executive committee of the staff and recently was its president. At the time of his death he was director of surgery. His death came suddenly in the evening shortly after his return home from the operating room.

T. Stewart Hamilton, director of the Hartford Hospital delivered several papers at a hospital institute in Mexico City in January. Dr. Hamilton is on the faculty of the institute which is part of the Latin-American program of the American Hospital Association and sponsored by the U. S. State Department. Dr. and Mrs. Hamilton moved on from

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Mexico to Havana, Cuba where the institute was repeated.

J. Grant Irving, medical director of the Aetna Life Insurance Company, may be proud of his son Rob even though the latter should select the diplomatic service, as is his intent, instead of medicine. After reading the interview with a Hartford physician which young Irving wrote for his school paper, the *Loomis Log*, it is quite evident that this boy has a natural talent for newspaper writing. The interview was one of a series written on the professions and having as its purpose the increased awareness of the student body in the education and work required of professional men.

Wilson Fitch Smith is the author of "Fad Reducing Diets vs. Sensible Eating," the leading article in the Hartford Health Department's November-December, 1956 issue of *Health Bulletin*.

Lawrence L. Malinconico of Hartford is the author of "Vaginal Smears in Pregnancy," published in the *American Journal of Obstetrics and Gynecology*, January, 1957.

Hector M. Stevenson of West Hartford, an associate medical director of the Aetna Life Insurance Company, died at the Hartford Hospital on February 5 at the age of 71.

CHANGES AT INSTITUTE OF LIVING

The Institute of Living has decided to abandon its program of conferences for its residents by distinguished visitors. This program was instituted by Dr. Burlingame nine years ago and is now to be replaced by the procedure whereby staff officers will be sent away to various teaching centers for a period of time. Also distinguished visitors will come to the Institute for periods of a week each to conduct seminars, case discussions, and instruction in various aspects of psychiatry. The first of these lecturers this year was Leo H. Bartemeier, medical director of Seton Institute.

BRISTOL HOSPITAL EXPANDS ITS SURGICAL BUILDING

With a total overall cost of \$550,000, Bristol Hospital will expand the third and fourth floors of its surgical building this year. New intern quarters will also be built. The new additions will provide for 15 more beds, a new treatment room, two new operating rooms, a new cystoscopy room, a new recovery room accommodating six to eight patients, space for a central sterile supply unit, a dental room for oral surgery, and an unfinished storage area. All this is expected to be completed by April of this year.

THE TURBAN

Like the assemblies at the United Nations where but one turban is to be seen adorning the head of the Maharajah of Patiala, the operating floor, delivery rooms, and lecture halls of the Hartford Hospital have boasted one pastel-hued model crowning Dr. Pritam Singh of Amitsar, India. But now Dr. Singh has left, having spent a year in this country studying modern methods of anesthesiology and surgery. In addition to enjoying a residency in anesthesiology at the Hartford Hospital, Dr. Singh visited other hospitals such as the Massachusetts General in Boston and the Mayo Clinic in Rochester, Minnesota.

Dr. Singh made many friends. He returned to India and to his family after expressing gratitude for the many opportunities afforded him in the United States.

Litchfield County

The 192nd Mid-Winter Meeting was held at the Conley Inn, Torrington on January 22. The guest speakers were Dr. Augustus R. Felty of Hartford who spoke on "Social Security for the Physician," and Mr. Arnold P. Olson, executive secretary, Fairfield County Medical Association, who spoke on "An alternative to Social Security for the Physician." Both dissertations were of considerable interest to the members.

Middlesex County

Paul R. Felt, a member of the medical staff of the State Hospital in Middletown for 28 years prior to his retirement, died in East Hampton on February 5 at the age of 74.

William Chen, formerly the city health officer and more recently on the staff of the Connecticut State Hospital, is now in Washington at the National Cancer Institute.

James Glessner and Walter Nelson attended the annual meeting of the American Academy of Orthopedic Surgeons in Chicago the last week in January.

Frank Kivlahan, a graduate of Queens University Medical School in Belfast, North Ireland, joined the intern staff at the Middlesex Memorial Hospital on January 1.

Michael Valleri opened an office for the general practice of medicine at 124 Main Street in Middletown.



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The annual meeting of the Central Medical Association of Middletown was held at the Commodore Macdonough Inn. New officers were elected as follows: President, Clarence Harwood; Vice President, Sanford Harvey; Secretary, James Glessner; Treasurer, Joseph Epstein. The speaker of the evening, Dr. Thomas Malone, meteorologist at the Travelers Weather Service, spoke on "Modern Day Weather Forecasting." He gave us an insight into the difficulties of predicting the weather.

New Haven County

The New Haven Mayor's Commission has recommended that the General Assembly prohibit the practice of nursing by unlicensed persons. At the same time the Commission suggested that a voluntary agency such as Family Service of New Haven be asked to provide a registration service for persons seeking employment to render personal care in homes. Members of the Commission include the following physicians: Creighton Barker, executive secretary of the State Medical Society; Clement F. Batelli, New Haven director of public health; Paul F. McAlenney, chief of pediatrics at St. Raphael's Hospital; Robert Salinger, associate clinical professor of pediatrics; and William E. Swift, secretary of the New Haven Medical Association.

Orvan W. Hess of New Haven presented a paper (by invitation) on "Studies on Fetal Electrocardiography" at the meeting of the American College of Surgeons at San Juan, Porto Rico in January. The material presented in this paper was done by the author in collaboration with Edward H. Hon and C. Lee Buxton at the Yale University School of Medicine.

Edward H. Hon and Orvan W. Hess of New Haven received the Third Award for their exhibit on "A Study of Fetal Cardiac Energy" at the recent meeting of the American College of Obstetricians and Gynecologists held in Chicago.

The leading article in the *Journal of the American Medical Association*, December 29, 1956, entitled "Indications For Vaccination Against Poliomyelitis," was written by John R. Paul of New Haven and presented at the AMA sessions in Chicago last June.

WATERBURY MEDICAL ASSOCIATION 100 YEARS OLD

The Waterbury Medical Association began its centennial celebration with a dinner on February 5. Other events planned are a lecture for the public this spring, a three day exhibit entitled "One Hun-

dred Years of Medicine in Waterbury" this autumn, and in December a lecture on "One Hundred Years of Medicine in Connecticut" by the librarian of the Yale University School of Medicine.

New London County

Alfred Labensky was tendered a testimonial dinner at Lighthouse Inn on January 7 by his colleagues for his service, as chief of staff at Lawrence Memorial Hospital. Dr. Labensky's period of service to the hospital in this capacity has been continuous since 1934 except for an interval of three years. In addition to his hospital service, Dr. Labensky's civic services were noted. Judge Troland a schoolmate, Mr. Hancock, hospital administrator, and several fellow physicians took part in the after-dinner program.

Windham County

Sidney Vernon of Willimantic is the author of "The Importance of Ground Substance in Surgical Concepts" published in *The American Journal of Surgery*, September, 1956. Also an editorial titled "The Unit of Function" appeared in the same issue.

Yale University School of Medicine

Athletics and other news of interest to Yale alumni have yielded the spotlight to information on cancer in the January, 1957 issue of *Yale Alumni Magazine*. Dean Lippard of the Medical School leads off with an article on "Cancer Research at Yale." This followed in order by "The Biological Characteristics of Cancer," written by Harry S. N. Greene, professor of pathology; "Hormones and the Cancer Problem" by William U. Gardner, professor of anatomy; "Viruses as Etiological Agents of Cancer" by Francisco Duran-Reynals, research associate in microbiology; "Metabolic Approaches to Chemotherapy of Cancer" by Arnold D. Welch, professor of pharmacology; "Radiation of Cancer" by Alfred J. Kummer, assistant professor of radiology; "Treatment of Cancer by Surgery" by Mark A. Hayes, associate professor of surgery; and "Leukemia Research" by Stuart C. Finch, assistant professor of medicine.

This is a heavy diet for any layman but the articles are short, informative and should provide an up-to-date snapshot of the cancer field. They are timely when our lay magazines have gone on a rampage in publishing medical information and sometimes, unfortunately, misinformation.

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SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL MIDDLETOWN, CONNECTICUT

Schedule of Noon Conferences for March 1957

Friday, March 1, noon
Grand rounds

Monday, March 4, noon
Clinical-pathologic conference

Wednesday, March 6, 10 A. M.
Tumor conference

Friday, March 8, noon
William J. Lahey, M.D., director of Medical Education,
St. Francis Hospital, Hartford
Chronic pulmonary insufficiency

Monday, March 11, noon
Grand rounds

Friday, March 15, noon
Grand rounds

Monday, March 18, noon
Stewart C. Finch, M.D., chief, Section of Hematology
Department of Internal Medicine, Yale University
School of Medicine
Hazards of transfusion

Friday, March 22, noon
Grand rounds

Monday, March 25, noon
Mark A. Hayes, M.D., associate professor of Surgery,
Yale University School of Medicine
Management of polyps of rectum and colon

Wednesday, March 27, noon
Gilbert H. Glaser, M.D., chief, Section on Neurology,
Yale University School of Medicine, Department of
Internal Medicine
Parkinsonism

Friday, March 29, noon
Grand rounds

REGIONAL MEETING OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY

A regional meeting of the Central Region of the American College of Gastroenterology will be held in Grand Rapids, Michigan, Sunday afternoon, March 17, 1957. The scientific sessions will be at the Hotel Pantlind commencing at 1:45 P. M.

Participating in the program will be Joseph B. Kirsner, M.D., Chicago, Illinois; William Fuller, M.D., Grand Rapids, Michigan; Joseph Shaiken, M.D., F.A.C.G., Milwaukee, Wisconsin; C. Wilmer Wirts, M.D., F.A.C.G., Philadelphia, Pennsylvania; Garnet Ault, M.D., Washington, D. C.; Don W. McLean, M.D., Detroit, Michigan; Frederick A. Collier, M.D., Ann Arbor, Michigan; Fred Hodges, M.D., Ann Arbor, Michigan and C. Allen Payne, M.D., Grand Rapids, Michigan.

There will be three individual papers and a panel discussion on "Gastrointestinal Bleeding" moderated by Dr. Collier with the speakers of the afternoon as the participants.

Members of the medical profession are cordially invited to attend. A copy of the program may be obtained from the secretary, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Postgraduate Course on Diseases of the Chest
Philadelphia, Pennsylvania
April 1-5, 1957

30th ANNUAL SPRING CONGRESS IN OPHTHALMOLOGY AND OTOLARNGOLOGY AND ALLIED SPECIALTIES

Patrick Henry Hotel, Roanoke, Virginia
April 1-6, 1957

Program arranged by Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia. Matriculation fee \$80. For particulars write E. G. Hill, M.D., Roanoke, Virginia.

HARTFORD HOSPITAL

Saturday Morning, 11 o'clock Guest Speakers
April 6 to June 1, 1957

April 6

John D. Crawford, M.D., associate pediatrician, Massachusetts General Hospital; assistant professor of Pediatrics, Harvard Medical School

Endocrine problems in childhood

April 13

Arthur T. Hertig, M.D., professor of Pathological Anatomy, Harvard Medical School

10 A.M. CA of endometrium

11 A.M. CA of cervix

April 20

Donald D. Matson, M.D., assistant professor of Surgery, Harvard Medical School; associate Neurosurgeon, Peter Bent Brigham Hospital and Children's Hospital, Boston

Benign intracranial tumors of childhood

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April 27

David V. Habib, M.D., associate professor of Clinical Surgery, Columbia College of Physicians & Surgeons
The problem of lymphedema of the arm

May 4

Benjamin Tenney, M.D., professor of Obstetrics, Boston University School of Medicine
10 A.M. The pregnant cardiac
11 A.M. Hypertension in pregnancy

May 11

John Paul, M.D., professor of Preventive Medicine, Yale University School of Medicine (Dwight Griswold Memorial Lecture)
Immunization in polio, 1957

May 18

Chester Keefer, M.D., professor of Medicine, Boston University School of Medicine
The treatment of subacute bacterial endocarditis

May 25

Thomas Durant, M.D., professor of Medicine, Temple University School of Medicine, Philadelphia
10 A.M. Case presentation—cardiac problems
11 A.M. Visualization of coronary blood flow

June 1

S. J. Thannhauser, M.D., emeritus professor of Medicine, Tufts University School of Medicine
Case presentation

Second New England Conference on Rural Health
Pembroke, New Hampshire
April 25, 1957

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AMA COMMITTEE ON FEDERAL MEDICAL SERVICES

April 6 in New York City for the New England and Middle Atlantic area. Principal discussion topic will be the AMA policy on care for veterans with nonservice connected disabilities in Veterans Administration hospitals.

BAHAMAS MEDICAL CONFERENCE

Bahamas Branch, British Medical Association, Nassau, Bahamas, April 23-30, 1957.

Hotel reservations should be made as early as possible by writing (airmail ten cents postage from the United States or Canada) directly to Mr. Robert K. Holiday, reservations manager, British Colonial Hotel, Nassau, Bahamas, and by sending at the same time the registration fee of \$75.

THE NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL

Announces seminar in Internal Medicine. A survey of the field of internal medicine. April 8 through May 31, 1957.

For further information write: Office of the Dean, NYU Post-Graduate Medical School, 550 Fifth Avenue, New York 16, N. Y., a unit of New York University-Bellevue Medical Center.

NEW YORK MEDICAL COLLEGE METROPOLITAN MEDICAL CENTER

Announces the first American Post-Graduate Assembly in Fertility and Sterility at New York Medical College and affiliated hospitals in New York City, May 18-31, 1957.

This will be an intensive two-week course in all aspects of fertility and sterility. The medical college faculty and noted guest professors will make up the teaching staff. The course consists of lectures, demonstrations, round-tables, operative clinics including culdoscopy, ward rounds and specialty-clinic case presentations.

Emphasis will be placed on the clinical aspects of human infertility including all recent advances in diagnosis and therapy. Special sessions will cover methods and problems

CONFERENCE ON INFERTILITY

U. S. Section of International Fertility Association, The Greenbrier, White Sulphur Springs, West Virginia, April 22-24, 1957. For further information write Charles S. Mahan, M.D., 8 Charlestown Avenue, Morgantown, West Virginia.

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The course is conducted by the Department of Obstetrics and Gynecology, Dr. Martin L. Stone, director; and is under the supervision of Dr. Abner I. Weisman, chief, Section of Sterility and Fertility.

For further information and application forms, write to: Dr. Ralph F. Snyder, dean, New York Medical College, 1249 5th Avenue, New York 29, N. Y. Registration limited. Tuition fee \$150.

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For further information about these and other courses offered during the academic year: the dean, Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

WORLD CONGRESS OF GASTROENTEROLOGY

Sheraton Park Hotel, Washington, D. C.

May 25-31, 1958

Major subjects to be considered at the scientific session are peptic ulcer, malabsorption and sprue-like syndromes, nutrition and its effect on the liver and pancreas, intestinal infection and infestation, and cancer of the stomach.

All physicians interested in gastroenterology are cordially invited to attend.

For detailed information write H. M. Pollard, M.D., secretary-general, University Hospital, Ann Arbor, Michigan.

American Medical Association

New York City

June 3-7, 1957

23rd New England Health Institute

University of Massachusetts, Amherst, Massachusetts

June 13-15, 1957

**AMA SPONSORS "NOMENCLATURE"
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The American Medical Association recently announced that a short course on the use of the Standard Nomenclature of Diseases and Operations in the doctor's office, clinic or hospital will be held June 17-19 at the Indiana University Medical Center, Indianapolis. This three day meeting is conducted by the AMA as a special service to medical record librarians and others using the Nomenclature in their work. Tuition is free. Applications should be sent to Mrs. Adaline C. Hayden, C.R.L., associate editor of the *Nomenclature*, at AMA headquarters, Chicago.

NEW BOOKS IN REVIEW

THE NEUROSES IN CLINICAL PRACTICE. By Henry P. Laughlin. Philadelphia and London: W. B. Sanders Co. 1956. 802 pp.

Reviewed by WILLIAM W. ZELLER

There has long been a need for an authoritative text book on the neuroses, which would be instructive to persons of different interest groups. Dr. Laughlin has fulfilled this need in his book, *The Neuroses in Clinical Practice*. It contains useful and valuable information for the medical student, the general practitioner, the medical and surgical specialist, as well as for the practicing psychologist, social worker and psychiatrist.

The outstanding feature of the book is in the organization of its subject matter which is presented in clear unsophisticated language and outline.

The author first discusses the nature and origin of anxiety and shows how it functions to preserve and to protect the individual against the noxious effects of stressful internal or external environmental situations. He next details the intra-psychic mechanisms of defense which patients use to cope with the anxieties of every day living. The author then discusses each of the major neuroses, such as anxiety reaction, the phobic reaction, the conversion reaction, the dissociative reaction, depression, the fatigue reaction, hypochondriasis, the obsessive compulsive reaction, and the neuroses following trauma.

Each chapter follows a form, in which is presented a definition of the problem, an historical background of the illness, a diagnostic consideration with detailed description of symptomatology, a discussion of the psychodynamics and psychopathological aspects of the subject and finally the section devoted to therapy. Points of emphasis are illustrated with well chosen case presentations, carefully planned tables and charts, as well as abundant foot notes and bibliographies. Excellent summaries of sections and chapters appear frequently to assist the reader. A complete glossary of psychiatric terms is included at the end of the book.

For the general, medical and surgical practitioner, chapters on depression, fatigue reactions and hypochondriasis are of special value, since from the diagnostic standpoint these reactions are often missed in patients who present vague and unspecific physical complaints. In his discussion of the depressive reactions, however, the author tends to undervalue the importance of electroconvulsive treatments in such conditions.

Dr. Laughlin also introduces new terms and concepts which may or may not find a permanent place in psychiatric terminology. The first of these is the King David reaction, named after a classical example from biblical history. It may be defined as "an intra-psychic defensive process" through which the condemnation and hatred of the consciously disowned aspect of the self become consciously experienced as dislike for another person. Another new term proposed by the author is that of "the soteria" or "the converse of the phobia." The soteria is a reaction

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through which security and protection out of proportion to the stimulus are experienced by the individual as coming from an external object.

Dr. Laughlin is to be commended for his prodigious achievement in presenting a clear picture of the clinical neuroses. His book should be included in the library of every practicing physician who is interested in learning more concerning modern psychiatric theory and practice.

EPILEPSY AND THE LAW: A Proposal for Legal Reform in the Light of Medical Progress. By Roscoe L. Barrow and Howard D. Fabing, M.D. New York: Paul B. Hoeber, Inc. 1956. 177 pp. \$5.50.

Reviewed by JOHN DONNELLY

A physician and a lawyer have collaborated to present an evaluation of the laws which militate against the person suffering from epilepsy: that is, those laws relating to marriage, eugenics, sterilization, driving licenses, and workmen's compensation. A great amount of research has been put into this undertaking and the findings and conclusions are concisely tabulated. Attention is drawn to the emotional stress and the isolation imposed upon such persons by these inequities and to the inevitable evasion of the laws which must occur.

This slim volume is a special plea for public and professional understanding of the problem as a prelude to social and legal changes. In addition to emphasizing the sacrifice of strong moral and ethical values of the society imposing these restrictions, emphasis is placed on the anachronism of the present statutes, many of which were enacted several decades ago when knowledge of the etiology of the disorder was meager and when public opinion was influenced by almost superstitious fears. The fallacy of the inheritable nature of epilepsy itself is exposed, for the inheritable factor is a tendency which is a recessive characteristic carried by ten people for every case of overt seizures. That persons whose epilepsy is of medical origin, such as brain injury, encephalitis, etc., should be subjected to eugenic and sterilization laws is an obvious injustice, even if the premise with regard to inheritability were correct. The most convincing and readable chapter is that dealing with workmen's compensation laws and the difficulties of the epileptic person, including those completely controlled, in obtaining employment. It would appear to carry conviction because epilepsy is dealt with as if it were a medical condition comparable with other medical disorders which might just as readily be subjected to the same type of laws. The plea that persons suffering from epilepsy be regarded as human individuals is indeed strong but it loses some of its force by the constant repetition that such persons should not be regarded in the same way as the mentally ill and the feeble-minded. While the authors state that "intelligent understanding leaves no room for stigmatizing any of these conditions," nevertheless it might well be that a plea for the same sort of understanding of the mentally ill person would re-influence the appeal for the epileptic.

One weakness of the work is redundancy. While a certain amount of repetition is necessary because of the structure of the study, frequent reiteration of a point within a given chapter detracts from the power of the argument.

Recommendations are set out as to the form and content of laws dealing with the problem. Solutions are offered which would remove the inequities and injustice of present statutes and at the same time adequately protect the rest of society. The effectiveness of the new Wisconsin statute in this regard is brought forward as evidence that much progress can be made. The appendices include the Wisconsin statute with regard to driving licenses as well as bills before the Ohio and Illinois legislatures.

PRINCIPLES OF CLINICAL ELECTROCARDIOGRAPHY. By Mervin J. Goldman, M.D. Los Altos, California: Lange Medical Publications. 310 pp. \$4.50.

Reviewed by RUDOLPH V. LAMOTTA

This is the first review book of electrocardiography by Lange Medical Publications. The author has presented a difficult subject in a lucid manner so that student and practitioner will find it practical and stimulating. It is complete in its coverage of the subject and certainly fulfills the author's intention to present an elementary and functional survey of general principles.

The book explains the bipolar and unipolar leads, describes the essentials of muscle electrocardiography in relation to the derivation of the complexes and includes an excellent section on normal complexes and their variations.

The origins and explanations of the many normal and abnormal complexes conform to the most acceptable theories. Consequently, the beginner or those who wish to review basic principles will find technical details and conflicting opinion conspicuously absent for the sake of clarity and simplicity.

Each chapter discusses an important phase of electrocardiographic patterns with abundant examples and interpretations and special emphasis on hypertrophy, ischemia and infarction. The author's coverage of the arrhythmias is adequate and includes a wide variety of explanatory diagrams and representative tracings. In keeping with simplicity, the combinations of rhythm disturbances are not illustrated and this feature avoids the complexities which, at times, serve only to confuse the reader.

In brief, Dr. Goldman and Lange Medical Publications have prepared an excellent practical handbook of electrocardiography.

THE PHILOSOPHY OF MEDICINE. By William R. Laird, M.D. Charlestown, West Virginia: Education Foundation, Inc. 1956. 64 pp. \$3.

Reviewed by STANLEY B. WELD

In this mechanistic and materialistic world of ours it would benefit every physician to pause long enough to read this little book. There is much sound advice to be found between its covers, advice which, if followed, should be invaluable especially for the younger generation of physicians.

The author discusses his philosophy under five headings: logic, esthetics, ethics, politics and religion. The emphasis he places on careful case records in the chapter on logic is timely. So many valuable experiences are not properly

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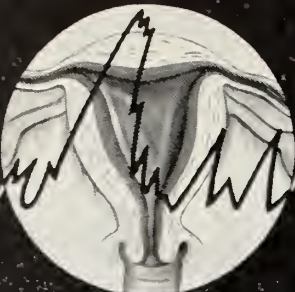
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Phenylephrine Hydrochloride	10.0 mg.

Robins

recorded and thus lost to posterity. More necropsies are encouraged. Development of an interest in art, music and the like for our own education and for its secondary effect on our patients through our conduct is desirable. Principles of ethics should need no emphasis. The author reminds us of the importance of adherence to them. His chapter on politics is an encouragement for the physician to take his proper place in community life and assume his share of responsibility, and in the final chapter on metaphysics he reminds the reader that his patient has a soul as well as a body and that the physician must be a philosopher as well as a technician.

One of the final paragraphs sums up the theme of the book in these words:

"The fivefold application of philosophy to medicine leaves us with high goals to push forward to. Logic demands that we think without confusion clearly; and that we reorganize knowledge in the light of experience! Esthetics requires us to be gentlemen in the fine old sense of that word, and to introduce our patients to the value of beauty. Ethics requires strict professional integrity in all our dealings. Politics will lead us to a knowledge of and a participation in the highest type of social organization. Metaphysics will keep us assured of the essential dignity of the individual, the possibilities of the human soul, the spiritual foundations of life, deeper than any creeds or ecclesiastical patterns."

CROSSING THE CONNECTICUT

HARTFORD TO EAST HARTFORD

- 1681—Thomas Caldwell granted the right to operate the first ferry from the foot of the present Ferry Street, Hartford
- 1801—First bridge built. An open structure with low solid-boarded sides and a toll house on the central pier
- 1818—Bridge washed away by ice freshet
- 1818—Wooden covered toll bridge built. Ferry operated from eastern end during freshet time
- 1859—Causeway built to replace ferry service
- 1904—Present stone bridge built



WOODEN TOLL BRIDGE ACROSS THE CONNECTICUT RIVER
HARTFORD — EAST HARTFORD

The CONNECTICUT STATE MEDICAL JOURNAL

VOL. XXI

APRIL, 1957

No. 4

165th ANNUAL MEETING of the CONNECTICUT STATE MEDICAL SOCIETY

EAST HARTFORD HIGH SCHOOL

777 Burnside Avenue, East Hartford, Connecticut

April 30, May 1, 2, 1957

PROGRAM COMMITTEE

JAMES W. MAJOR, *Willimantic, Chairman*

ARTHUR EBBERT, JR., *New Haven*

WILLIAM J. LAHEY, *Hartford*



JAMES W. MAJOR



T. STEWART HAMILTON

LOCAL COMMITTEE ON ARRANGEMENTS

T. STEWART HAMILTON, *Hartford, Chairman*

ALEXANDER E. BAYER, *New Britain*

SIDNEY L. CRAMER, *Hartford*

JOHN J. HOULIHAN, *Hartford*

WILLIAM H. LOHNAN, *East Hartford*

JOHN MURPHY, *East Hartford*

D. SERGEANT PEPPER, *Hartford*

PROGRAM

Tuesday, April 30

AUDITORIUM

ANNUAL MEETING OF THE HOUSE OF DELEGATES

COLF B. GIBSON, *Meriden, Speaker of the House, presiding*

10:00 CALL TO ORDER

BUSINESS SESSION

1:00 LUNCHEON FOR OFFICERS, MEMBERS OF THE HOUSE, AND GUESTS

2:00 RESUMPTION OF BUSINESS

7:00 ANNUAL DINNER OF THE COUNCIL—The Council will hold its annual dinner for the Program Committee, the Local Committee on Arrangements, and guests at the University Club, Hartford



EAST HARTFORD HIGH SCHOOL

ART EXHIBIT

CONNECTICUT PHYSICIANS' ART ASSOCIATION

John M. Freiheit, 85 Grove Street, Waterbury, *Chairman*
Mrs. Ralph T. Ogden, 15 Thicket Lane, West Hartford, *Co-Chairman*
Mrs. Lewis Giffen, 28 Chapman Road, West Hartford, *Co-Chairman*

The 1957 exhibit of the Connecticut Physicians' Art Association will be held during the Annual Meeting in Rooms 25 and 26 of the East Hartford High School, 777 Burnside Avenue, East Hartford. Members of the Woman's Auxiliary to the Society will participate in the exhibit and as a special feature, children of members of the Society have been invited to submit entries.

Wednesday, May 1

9:00 REGISTRATION

AUDITORIUM

9:15 CALL TO ORDER—Ralph T. Ogden, *Hartford, President of the Society*

ADDRESS OF WELCOME—John N. Gallivan, *East Hartford, President, Hartford County Medical Association*

ARTHUR EBBERT, JR., *New Haven, presiding*

9:45 TRANQUILIZING DRUGS

John Donnelly, *Hartford; Acting Medical Director, Institute of Living, Hartford*

10:25 MANAGEMENT OF THE NEPHROTIC SYNDROME

Arnold S. Relman, *Boston; Associate Professor of Medicine, Boston University School of Medicine; Visiting Physician, Massachusetts Memorial Hospital, Boston*

11:05 INTERMISSION TO VISIT TECHNICAL EXHIBITS

WILLIAM J. LAHEY, *Hartford, presiding*

11:20 USE AND ABUSE OF LABORATORY PROCEDURES

David Seligson, *Philadelphia; Director of the Division of Biochemistry, Graduate Hospital, University of Pennsylvania; Assistant Professor, Internal Medicine, Graduate School of Medicine, University of Pennsylvania*

THOMAS J. DANAHY, *Torrington, presiding*

12:00 PANEL ON MEDICAL CARE INSURANCE: ITS INFLUENCE ON MEDICAL SERVICE

Donald Stubbs, *Alexandria, Virginia; Chief of Staff, Doctors' Hospital; Clinical Professor of Anesthesiology, George Washington University*

Norman A. Welch, *Boston; Physician-in-Chief, Carney Hospital, Boston; Clinical Professor of Medicine, Tufts College Medical School*

Mr. Louis A. Orsini, *New York; Assistant Director of Information and Research, Health Insurance Association of America; Lecturer, Insurance Society of New York*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

PROGRAM ARRANGED BY CONNECTICUT CHAPTER—AMERICAN ACADEMY OF GENERAL PRACTICE

President: Richard B. Elgosin, Hamden

Secretary: Peter J. Scafarello, Hartford

RICHARD B. ELGOSIN, *Hamden, presiding*

2:00 AN APPROACH TO THE PATIENT WITH HEADACHE

Perry S. MacNeal, *Philadelphia; Physician to the Pennsylvania Hospital*

2:40 THE INTERNIST LOOKS AT THE LUNG CANCER PROBLEM. An Analysis of 300 Consecutive Tissue Proven Cases

J. Antrim Crellin, *Philadelphia; Clinical Professor of Medicine, Hahnemann Medical College and Hospital of Philadelphia; Senior Visiting Physician, Hahnemann Hospital of Philadelphia; Clinical Chief of Chest Clinic, Hahnemann Hospital*

3:20 Discussion

ANNUAL MEETING PROGRAM

Speakers — Wednesday, May 1



John Donnelly, Hartford, Conn.; Acting Medical Director, Institute of Living, Hartford, Conn.



Donald Stubbs, Alexandria, Virginia; Chief of Staff, Doctors Hospital, Clinical Professor of Anesthesiology, George Washington University.



Arnold S. Relman, Boston, Mass.; Associate Professor of Medicine, Boston University School of Medicine; Visiting Physician, Massachusetts Memorial Hospital, Boston, Mass.



Norman A. Welch, Boston, Mass.; Clinical Professor Medicine, Tufts University Medical School; Physician-in-chief Carney Hospital, Boston.



David Seligson, Philadelphia, Pa.; Director of the Division of Biochemistry of the Graduate Hospital; Assistant Professor Internal Medicine, The Graduate School of Medicine of the University of Pennsylvania.



Louis A. Orsini, New York City; Assistant Director of Information and Research, Health Insurance Association of America, New York City.

Wednesday, May 1

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

THIRTEENTH ANNUAL MEETING

HARTFORD GOLF CLUB, WEST HARTFORD

President: Mrs. E. Roland Hill, *Mystic*

Secretary: Mrs. Saul Karpel, *New London*

10:00 Registration—Lobby

Business Meeting

Election of Officers

Memorial Service—Mrs. Stevens J. Martin, *Hartford*

12:00 Social Hour

1:00 Luncheon

INVOCATION—The Very Reverend John H. Esquirol, *Dean of Christ Church Cathedral, Hartford*

GUEST SOLOIST—Mary Langdon, Contralto, accompanied by William Dale

GUEST SPEAKERS

2:00 Thomas A. Hendricks, *Field Director, American Medical Association*

2:30 Mrs. Luther H. Kice, *Parliamentarian and Past President of the National Auxiliary to the American Medical Association*

3:00 Induction of Officers—Mrs. Luther H. Kice

Presentation of President's Pin—Mrs. E. Roland Hill, *Mystic*

Response by Incoming President—Mrs. Paul W. Tisher, *New Britain*

3:30 RECEPTION FOR PAST PRESIDENTS OF THE WOMAN'S AUXILIARY

Residence of Dr. and Mrs. John D. O'Connell, 42 Fulton Place, West Hartford

SECTION ON DERMATOLOGY AND SYPHILOLOGY

3:30

Room 109

President: Neville Kirsch, *Hartford*

Secretary: Ellwood C. Wiese, Jr., *Bridgeport*

RECENT ADVANCES IN DERMATOLOGIC RESEARCH

A. Benson Lerner, *New Haven; Associate Professor of Medicine (Dermatology), Yale University School of Medicine*



Perry S. MacNeal, Philadelphia, Pa.; Physician to Pennsylvania Hospital.



J. Antrim Crellin, Philadelphia, Pa.; Clinical Professor of Medicine, Hahnemann Medical College & Hospital of Philadelphia; Senior Visiting Physician, Hahnemann Hospital of Philadelphia; Clinical Chief of Chest Clinic, Hahnemann Hospital.

Wednesday, May 1

SECTION ON GASTROENTEROLOGY

3:30 Choral Room

President: George P. Perakos, *New Britain*

Secretary: Max Caplan, *Meriden*

CORTICOIDS IN GASTROINTESTINAL DISEASES—Panel Discussion

Moderator: Howard M. Spiro, *New Haven*; *Assistant Professor of Medicine, Yale University School of Medicine; Associate Physician, Grace-New Haven Community Hospital; Attending Physician, Veterans Administration Hospital, West Haven*

Panel:

Mark A. Hayes, *New Haven*; *Associate Professor of Surgery, Yale University School of Medicine; Associate Surgeon, Grace-New Haven Community Hospital; Consultant, Veterans Administration Hospital, West Haven*

Gerald Klatskin, *New Haven*; *Associate Professor of Medicine, Yale University School of Medicine; Associate Physician, Grace-New Haven Community Hospital; Consultant, Veterans Administration Hospital, West Haven*

Henry J. Tumen, *Philadelphia*; *Professor of Clinical Gastroenterology, Graduate School of Medicine, University of Pennsylvania; Gastroenterologist, Albert Einstein Medical Center*

CONNECTICUT ASSOCIATION OF MEDICAL RECORD LIBRARIANS

10:00 Band Room

President: Mrs. Margaret Reeves, *New Haven*

Secretary: Miss Jean A. Feindt, *Hartford*

CARDIAC SURGERY

R. Leonard Kemler, *Hartford*; *Thoracic Surgeon. Staff affiliations: Cedarcrest Sanatorium, Chief of Staff; Mt. Sinai, McCook, St. Francis, and Hartford Hospitals*

MEDICAL RECORD PROBLEMS—Panel Discussion

CONNECTICUT CHAPTER OF NATIONAL ASSOCIATION OF SOCIAL WORKERS—
MEDICAL SOCIAL WORK SECTION

3:30 Room 110

Chairman: Dominic Accettullo, *New Britain*

Secretary: Barbara F. Davis, *Hartford*

EFFECTIVE CONFERENCE LEADERSHIP

David C. Phillips, PH.D., *Storrs*; *Head, Department of Speech and Drama, University of Connecticut, Storrs*

CONNECTICUT DIABETES ASSOCIATION

3:30 Room 108

President: Leonard A. Howard, *Cos Cob*

Secretary: James C. Hart, *Hartford*

CURRENT TRENDS IN NUTRITION: The Influence of Dietary Fat on Atherosclerosis in Relation to Diabetes

Herbert Pollack, *New York*; *Member, National Research Council on Nutrition; Assistant in Medicine and Lecturer, Clinical Medicine, Columbia University, College of Physicians and Surgeons, New York; Assistant in Medicine and Physician-in-Charge, Diabetes Clinic, Mt. Sinai Hospital*

CONNECTICUT OCCUPATIONAL THERAPY ASSOCIATION

3:30 Room 105

President: Mrs. Bess Lande, *New Haven*

Secretary: Miss Marian Maurer, *New Haven*

DIRECT AND INDIRECT EFFECTS OF TRANQUILIZING THERAPY

John Donnelly, *Hartford*; *Acting Medical Director, Institute of Living, Hartford*

Wednesday, May 1
ANNUAL DINNER OF THE SOCIETY
HARTFORD CLUB, HARTFORD

7:00

PROGRAM

RALPH T. OGDEN, *Hartford, presiding*

INTRODUCTION OF NEWLY ELECTED OFFICERS

PRESENTATION OF GUESTS AND DELEGATES FROM THE STATE MEDICAL SOCIETIES

FIFTY YEAR MEMBERSHIP AWARDS

Charles Thomas Beach, *Hartford*

Eugene Maurice Blake, *New Haven*

George Blumer, *Balboa Island, California*

Alice Porter Ford, *New Haven*

Charles Wesley Gardner, *Bridgeport*

Carl William Henze, *Hamden*

Thomas Norval Hepburn, *Hartford*

George Arthur Leonard, *Fort Pierce, Florida*

Howard DeForest Lockwood, *Meriden*

Robert Lee Rowley, *Hartford*

Paul Ulysses Sunderland, *Danbury*

J. Howard Staub, *New Preston*

Horace Cheney Swan, *Hartford*

Louis Frederick Wheatley, *Brookfield, Vermont*

Otto George Wiedman, *Hartford*



RUSSELL ROTH

AN OBLIQUE VIEW OF MEDICAL PUBLIC RELATIONS

Russell B. Roth, *Erie, Pennsylvania*; Past-President of the Erie County Medical Society; Trustee and Councilor of Medical Society of Pennsylvania; Fellow, American College of Surgeons

Reservations cards for the Annual Dinner will be included with the program of the meeting which will be distributed to all members; wives of members are invited to attend.

Wednesday, May 1

CONNECTICUT REGIONAL GROUP—MEDICAL LIBRARY ASSOCIATION

3:30 Room 104

President: Mrs. Jessie W. Kohl, *New London* Secretary: Mrs. Helen Lansberg, *Hartford*

WHAT THE RESEARCH WORKER EXPECTS FROM THE MEDICAL LIBRARY

Charles E. Henry, *Hartford*; *Director of Electroencephalography, Institute of Living, Hartford*

HEZEKIAH BEARDSLEY PEDIATRIC SOCIETY

3:30 Room 107

President: James M. Sturtevant, *New London* Secretary: Robert P. Rogers, *Greenwich*

PEDIATRIC PROBLEMS IN UNDERDEVELOPED COUNTRIES

Charles A. Janeway, *Boston*; *Thomas Morgan Rotch Professor of Pediatrics, Harvard Medical School*; *Chairman, Department of Pediatrics, Harvard Medical School*; *Physician-in-Chief, Children's Hospital, Boston*

Thursday, May 2

9:30 REGISTRATION

AUDITORIUM

JAMES W. MAJOR, *Willimantic*, presiding

10:00 ESTIMATION OF OPERATIVE RISK, 1957

SURGICAL ASPECTS—J. Garrett Allen, *Chicago*; *Professor of Surgery, School of Medicine, University of Chicago*; *Attending Surgeon, University of Chicago, Clinics*

MEDICAL ASPECTS—Clarence E. de la Chapelle, *New York*; *Professor of Medicine, New York University Postgraduate Medical School*; *Visiting Physician, Bellevue Hospital*

ANESTHESIA—Nicholas M. Green, *New Haven*; *Professor of Anesthesiology, Yale University School of Medicine*; *Director of Anesthesia, Grace-New Haven Community Hospital*

11:00 THE WORLD MEDICAL ASSOCIATION

Stanley B. Weld, *Hartford*, *U. S. Committee*

11:15 INTERMISSION TO VISIT TECHNICAL EXHIBITS

GUSTAF E. LINDSKOG, *New Haven*, presiding

11:30 THE CHANGING PICTURE OF PULMONARY SURGERY

Julian Johnson, *Philadelphia*; *Professor of Surgery, School of Medicine and Graduate School of Medicine, University of Pennsylvania*

12:05 MANAGEMENT OF ULCERATIVE COLITIS

SURGICAL ASPECTS—Paul Nemir, Jr., *Philadelphia*; *Associate Professor of Surgery, Graduate School of Medicine, University of Pennsylvania*; *Surgeon, University of Pennsylvania Graduate Hospital*

MEDICAL ASPECTS—Henry J. Tumen, *Philadelphia*; *Professor of Clinical Gastroenterology, Graduate School of Medicine, University of Pennsylvania*; *Gastroenterologist, Albert Einstein Medical Center*

1:00 LUNCHEON—Cafeteria of the High School

VISIT TO TECHNICAL EXHIBITS

ANNUAL MEETING PROGRAM

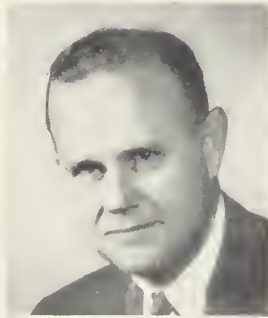
Speakers — Thursday, May 2



J. Garrott Allen, Chicago, Illinois; Professor of Surgery, School of Medicine, University of Chicago; Attending Surgeon, University of Chicago Clinics.



Nicholas M. Greene, New Haven, Conn.; Professor of Anesthesiology, Yale University School of Medicine; Director of Anesthesia, Grace-New Haven Community Hospital.



Julian Johnson, Philadelphia, Pa.; Professor of Surgery, School of Medicine and Graduate School of Medicine, University of Pennsylvania.



Paul Nemir, Jr., Philadelphia, Pa.; Associate Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Surgeon, University of Pennsylvania Graduate Hospital; Fellow of the American College of Surgeons.



Henry J. Tumen, Philadelphia, Pa.; Professor of Clinical Gastroenterology, Graduate School of Medicine, University of Pennsylvania; Gastroenterologist, Albert Einstein Medical Center.

Thursday, May 2

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

AUDITORIUM

PROGRAM ARRANGED BY THE CONNECTICUT SOCIETY OF AMERICAN BOARD SURGEONS

President: E. Cotton Rawls, *Stamford* Secretary: Eugene J. Fitzpatrick, *New Haven*
Program Chairman: Mark A. Hayes, *New Haven*

E. COTTON RAWLS, *Stamford*, presiding

2:00 VASCULAR EMERGENCIES OF INTEREST TO THE GENERAL PHYSICIAN: THEIR RECOGNITION AND TREATMENT

Harris B. Shumacker, Jr., *Indianapolis, Indiana*; Professor of Surgery and Chairman of the Department, *Indiana University Medical Center*

2:40 COMMON ERRORS IN THE DIAGNOSIS OF ACUTE ABDOMEN

Samuel J. Stabins, *Rochester, New York*; Associate Professor of Surgery, *University of Rochester School of Medicine and Dentistry*; Surgeon-in-Chief, Emeritus, *Genesee Hospital*



Harris B. Shumacker, Jr., *Indianapolis, Indiana*; Professor of Surgery and Chairman of the Department, *Indiana University Medical Center*.



Samuel J. Stabins, *Rochester, New York*; Associate Professor of Surgery, *University of Rochester School of Medicine and Dentistry*; Surgeon-in-chief Emeritus, *Genesee Hospital, Rochester, New York*.

SECTION ON ANESTHESIA

3:30 Room 109

President: Leopold M. Trifari, *New Haven* Secretary: Edward J. Platz, *Manchester*

FLUOTHANE

John Abajian, Jr., *Burlington, Vermont*; Professor of Anesthesiology, *University of Vermont*; Chairman of Division of Anesthesiology, *Mary Fletcher Hospital, Burlington, Vermont*

SECTION ON INDUSTRIAL HEALTH

3:30 Room 104

President: J. Wister Meigs, *New Haven* Secretary: Preston N. Barton, *Meriden*

Business Meeting

Thursday, May 2

EYE, EAR, NOSE AND THROAT SECTION

3:30

President: Max Alpert, *Bridgeport*

Secretary: Frederick A. Wies, *New Haven*

(There will be two separate programs, one for the Eye Section, and one for the Ear, Nose and Throat Section)

Room 114

DISEASES OF THE OPTIC NERVE

Frank D. Carroll, *New York*; Associate in Ophthalmology, *Columbia University, College of Physicians and Surgeons*

Room 108

MANAGEMENT OF FACIAL PARALYSIS

Frank D. Lathrop, *Boston*; Associate Otologist, *Lahey Clinic, Boston*

5:00 Combined business meeting—Room 114

6:00 Social Hour—Location to be announced

7:00 Dinner—Location to be announced

SECTION ON UROLOGY

3:30

Room 107

President: Henry M. Pollock, *Bristol*

Secretary: Richard J. Spillane, *Hartford*

RADIOLOGIC PRESENTATION OF UNUSUAL CASES

Max Ritvo, *Boston*; Roentgenologist-in-Chief and Director, Department of Radiology, *Boston City Hospital*; Assistant Clinical Professor of Radiology, *Harvard Medical School*

JOINT MEETING

HUNT MEMORIAL, SCARBOROUGH STREET AND ALBANY AVENUE, HARTFORD

SECTION ON ORTHOPEDICS

President: George G. Fox, *Meriden*

Secretary: Russell V. Fuldner, *New Haven*

SECTION ON RADIOLOGY

President: William A. Goodrich, *Hartford*

Secretary: Ralph J. Littwin, *Bristol*

5:00 Combined panel discussion of problem cases (x-rays)

6:30 Social Hour

7:30 Dinner

8:45 Guest Speaker—David Bosworth, *St. Luke's Hospital, New York*
"EVALUATING A FRACTURE"

JOINT MEETING

3:30 Choral Room

CONNECTICUT ASSOCIATION OF MEDICAL EXAMINERS

President: Edmund L. Douglass, *Groton*

Secretary: Samuel B. Rentsch, *Derby*

CONNECTICUT SOCIETY OF PATHOLOGISTS

President: Ronald S. Beckett, *Hartford*

Secretary: Christie E. McLeod, *Middletown*

Subject to be announced

Lester Adelson, *Cleveland, Ohio*; Deputy Coroner, *Cuyahoga County, Cleveland*; Instructor, *Legal Medicine, Western Reserve School of Medicine, Cleveland*

Thursday, May 2

CONNECTICUT SOCIETY OF AMERICAN BOARD OBSTETRICIANS AND
GYNECOLOGISTS

3:30 Band Room

President: Lewis P. James, *Hartford*

Secretary: Joseph Klein, *Hartford*

ROUND TABLE DISCUSSION OF CYTOLOGIC AND HISTOLOGIC METHODS FOR DIAGNOSIS OF PRECANCEROUS
STATES AND EARLY CARCINOMA OF THE UTERUS

Leon Motyloff, *New York; Pathologist, Woman's Hospital, New York*

Ralph E. Kendall, *Hartford, Pathologist, Hartford Hospital, Hartford*

SECTION ON PHYSICAL MEDICINE

4:00 Auditorium

President: Samuel A. Schuyler, *Hartford*

Secretary: H. Bruno Arnold, *New Haven*

ELECTROPHYSIOLOGY IN RELATION TO PHYSICAL MEDICINE (Involving EMG-EEG)

Wladimir T. Liberson, *Hartford; Chief, Physical Medicine and Rehabilitation Service, Rocky Hill, Connecticut; Veterans Administration Hospital, Northampton, Massachusetts*

CONNECTICUT DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

3:30 Room 110

President: Harold S. Wright, *Greenwich*

Secretary: James C. Johnson, Jr., *Hartford*

PSYCHIATRY IN THE GENERAL HOSPITAL

John M. Cotton, *New York; Director, Psychiatric Service, St. Luke's Hospital, New York*

Discussant: Benjamin Wiesel, *Hartford; Chief, Department of Psychiatry, Hartford Hospital, Hartford*

CONNECTICUT ALLERGY SOCIETY

3:30 Room 105

President: George H. Hurwitz, *Hartford*

Secretary: I. H. Krall, *Hartford*

PANEL DISCUSSION—PULMONARY EMPHYSEMA AND RELATED TOPICS

Robert P. McCoombs, *Boston; Director of Pratt Diagnostic Clinic; Professor of Medicine and Director, Postgraduate School of Tufts College Medical School, Boston*

Irving W. Schiller, *Boston; Assistant Professor of Medicine, Boston University School of Medicine*

CONNECTICUT CHAPTER—AMERICAN PHYSICAL THERAPY ASSOCIATION

1:00 Choral Room

President: James M. Bauer, *Storrs*

Secretary: Wilhelmena Werkhoven, *Rockville*

PROPRIOCEPTIVE FACILITATION IN NEURO-MUSCULAR RE-EDUCATION

Herman Kabat, *Providence, Rhode Island; Director of Physical Medicine and Rehabilitation, Meriam Hospital, Providence*

The Physical Therapy Association will join the Section on Physical Medicine in the Auditorium.

CONNECTICUT RHEUMATISM ASSOCIATION

3:30 Room 115

President: Harold J. Lehmus, *Manchester*

Secretary: Harold S. Barrett, *Hartford*

THE PATHOGENESIS OF RHEUMATOID ARTHRITIS

J. Peter Kulka, *Boston; Associate in Pathology, Harvard Medical School*

Technical Exhibits — 1957 Annual Meeting

<i>Space</i>	<i>Firm</i>	<i>Location</i>
1	E. F. Mahady Company	Boston, Mass.
2	A. H. Robins, Inc.	Richmond, Va.
3	Burroughs-Wellcome & Co. (U.S.A.) Inc.	Tuckahoe, N. Y.
4	The G. F. Harvey Company	Saratoga Springs, N. Y.
5	American Ferment Company, Inc.	New York, N. Y.
6	E. R. Squibb & Sons	New York, N. Y.
7	Thermo-Fax Sales of Connecticut, Inc.	Hamden, Conn.
8	The D. G. Stoughton Company	Hartford, Conn.
9	Lederle Laboratories Division, American Cyanamid Company	Pearl River, N. Y.
10	Mead Johnson & Company	Evansville, Ind.
11	Surgeons & Physicians Supply Company	Boston, Mass.
12	The National Drug Company	Philadelphia, Pa.
13	Seven-Up Bottling Company, Inc.	East Hartford, Conn.
14	Connecticut Medical Service	New Haven, Conn.
15	American Surgical Supply & Equipment Company	Bridgeport, Conn.
17	Doho Chemical Corporation	New York, N. Y.
18	The E. S. Pierce Company (Domore Chair Co.)	Hartford, Conn.
19	Eli Lilly and Company	Indianapolis, Ind.
20	Endo Laboratories, Inc.	Richmond Hill, N. Y.
21	Sandoz Pharmaceuticals	Hanover, N. J.
22	Desitin Chemical Company	Providence, R. I.
23	Pfizer Laboratories	Brooklyn, N. Y.
24	Stuart Company	Burbank, Calif.
25	W. B. Saunders Company	Philadelphia, Pa.
26	C. B. Fleet Company, Inc.	Lynchburg, Va.
27	Eaton Laboratories	Norwich, N. Y.
29	Abbott Laboratories	North Chicago, Ill.
30	Merck, Sharp & Dohme	Philadelphia, Pa.
31	Ciba Pharmaceutical Products, Inc.	Summit, N. J.
32	Maltbie Laboratories Division	Belleville, N. J.
33	Schering Corporation	Bloomfield, N. J.
34	Ayerst Laboratories	Hackensack, N. J.
35	G. D. Searle & Company	Chicago, Ill.
36	Ames Company, Inc.	Elkhart, Ind.
37	Nepera Chemical Company, Inc.	Yonkers, N. Y.
38	E. Fougera & Company, Inc.	New York, N. Y.
39	A. S. Aloe Company	St. Louis, Mo.
40	Smith, Kline & French Laboratories	Philadelphia, Pa.
41	Purdue Frederick Company	New York, N. Y.
42-53	The Professional Equipment Company (merged with E. L. Washburn Co.)	New Haven, Conn.
43	Brewer & Company, Inc.	Worcester, Mass.
44	Picker X-Ray Corporation	White Plains, N. Y.
45	H. J. Heinz Company	Pittsburgh, Pa.
46	Riker Laboratories	Los Angeles, Calif.
47	Organon, Inc.	Orange, N. J.
48	Westwood Pharmaceuticals	Buffalo, N. Y.
49	Richard Danz & Sons	New York City
50	Pepperidge Farm, Inc.	Norwalk, Conn.
51	Sherman Laboratories	Detroit, Mich.
52	Warner-Chilcott Laboratories	Morris Plains, N. J.
54	The Coca-Cola Company	Atlanta, Ga.
55	U. S. Vitamin Corporation	New York, N. Y.
56-57	Sealy Mattress Company	Waterbury, Conn.
58	William S. Merrell Company	Cincinnati, Ohio
59	Carroll Dunham Smith Pharmacal Company	New Brunswick, N. J.
61	Geigy Pharmaceuticals. Division of Geigy Chemical Corporation	New York, N. Y.
62	J. B. Roerig & Company	Chicago, Ill.
63	Parke, Davis & Company	Detroit, Mich.
64	Ross Laboratories	Columbus, Ohio
65	The Baker Laboratories, Inc.	Cleveland, Ohio
66	Milex of New York	Long Island City, N. Y.

Exhibit Decorator

Robert E. Stacy, 1090 Page Boulevard, Springfield, Massachusetts

THE HIDDEN DIABETIC

ROSEMARY MURPHY, M.D., *Boston, Massachusetts*

SINCE 1948, when the first Diabetes Detection Drive was sponsored by the American Diabetes Association, there has been an increasing awareness of the fact that the condition of many individuals with diabetes mellitus remains undiagnosed. In fact, for each known diabetic there probably is one who is unrecognized. Some of these diabetics have classical symptoms of the disease but for one reason or another have not sought medical care. Many more, however, are completely asymptomatic and may, therefore, be accurately classed as hidden diabetics. Experience has shown that diabetes mellitus may exist for months or even years without any obvious impairment of health. Yet the seriousness of the complications often present when the diagnosis finally is made cannot help but raise the question as to whether an earlier diagnosis with earlier treatment might not have prevented, or at least delayed, such complications.

Educational programs followed by Diabetes Detection Drives serve to discover cases of obvious diabetes and some instances of hidden diabetes which have not been seen by a physician. The importance of such annual drives must not be minimized but, nevertheless, the chief site of diabetes detection remains the office of the physician. Within his own practice, each physician for 365 days each year must function as a Sherlock Holmes, a sleuth who discovers the hidden diabetic when the cardinal clues to the disease are lacking. Anyone can be a Holmes when the guilty party is caught in the act of committing a crime, but the real Sherlock saw clues where everyone else, including Scotland Yard, saw nothing.

To discover the hidden diabetic, the physician must look beyond symptoms and persistently and repeatedly test all those individuals who experience has shown belong to what may be called the prediabetic group.

Within the entire population, there is a group that is not diabetic, but is potentially so. They

The Author. *Member of Department of Internal Medicine, The Lahey Clinic, Boston, Massachusetts*

SUMMARY

Because there probably exists as many unrecognized diabetics as there are known ones the physician must be on the alert to detect these hidden diabetics. The prediabetic group especially are an important group which should be carefully evaluated.

The author outlines the characteristic of this prediabetic group, emphasizing family history, age, obesity, pregnancy history, glycosuria appearing during cortisone therapy and at the time of surgical operations. The importance of glycosuria at any time is stressed, likewise the effect of hyperthyroidism on a prediabetic. Refinements in technic for discovering the hidden diabetic are suggested.

have the inherited predisposition to diabetes and, given time and perhaps the fortuitous superposition of diabetogenic factors, eventually will become diabetics. In the early stages, the disease may be asymptomatic or hidden unless technics of searching and detection bring it to light. It has been estimated that the diagnosed group represents about one per cent of the population, and that the undiagnosed and the potential diabetics include about another four per cent.¹ Since the prediabetic group is the reservoir for the hidden diabetics, it is essential that the characteristics of this group be kept in mind constantly. In the following discussion, features that identify this group are taken up separately, although it must be borne in mind that a given individual may show more than one of the suspicious characteristics.

CHARACTERISTICS OF THE PREDIABETIC GROUP

FAMILY HISTORY OF DIABETES

The role of inheritance in diabetes has been well recognized, although there has been some contro-

versy with respect to the mode of inheritance. At present, evidence seems to indicate that the disease is inherited as a simple Mendelian recessive character.^{1,2} On this basis all of the offspring, when both parents are diabetic, will be predisposed to diabetes; when one parent is diabetic and the other nondiabetic, the offspring will either be carriers of the disease or one half will be diabetic. Consequently, such offspring must be tested repeatedly throughout their life span, since there is no means for detecting the age at which diabetes will develop.

It may be of some importance to emphasize that it is insufficient to ask merely whether anyone in the family has diabetes. Frequently a patient will answer this question in the negative. But when questioned as to whether any member of the family has ever had sugar in the urine, the answer will be "Yes."

AGE

The incidence of diabetes in the older age group is greater than in the population at large. With the increased proportion of the population surviving beyond 50 years of age, we must begin to consider age alone as making a person a diabetic suspect. For example, in the now famous diabetic survey conducted by Wilkerson and Krall³ in Oxford, Massachusetts in 1947, the median age of the newly diagnosed diabetic patient was 55 years. The total number of cases increased with each decade over 45 years. In a similar study in two Ontario communities reported by Kenny and Chute,⁴ over six per cent of the women between 50 and 69 years and the men between 60 and 69 years were found to be diabetic. Since the older diabetic patient is less likely to have significant diabetic symptoms than is the younger diabetic, a blood sugar test, in addition to the urinalysis, should be a routine part of the general examination.⁵

OBESITY

"Obesity is the commonest physical abnormality in the United States. Its incidence has been estimated to be one fifth of the population."⁶ The close association of diabetes with obesity is a well established clinical fact. The significance of the association is borne out by statistical studies which reveal that of persons developing diabetes after the age of 40 years, approximately 60 per cent were or had been excessively overweight, 25 per cent had been moderately overweight, and only 15 per cent had never been overweight.⁷

Obesity, acting alone, may not be sufficient to induce diabetes. Assuming an inherent predisposition to diabetes, however, obesity may be a significant factor in precipitating the disease. Experimentally, this has been nicely demonstrated by Long.⁸ Bilateral lesions properly placed in the hypothalamus in rats and moneys lead to the rapid development of obesity. A certain proportion of these animals develop a decrease in carbohydrate tolerance. This is particularly true in the rat if a portion of the pancreas—insufficient to cause diabetes—is removed. In the early phases of this experimental diabetes, weight reduction will effect a return of carbohydrate tolerance to normal but if the obesity is prolonged the diabetic state is irreversible.

The exact nature of the relationship between obesity and diabetes is not clear, but the theory suggested by Long⁸ is quite plausible. If an individual maintaining a constant body weight requires a certain daily production of insulin, it seems logical to assume that one who ingests food in excess of daily needs will require an additional output of insulin to be utilized in the deposition of fat. When this persists over a period of years it is to be expected that eventually the pancreas will be unable to meet the demands. Initially, a state of relative insulin deficiency occurs, and weight reduction will re-establish an equilibrium between the demand for and supply of insulin. Eventually, however, with persistence of the relative insulin deficiency and intermittent or persistent hyperglycemia, an irreversible stage of diabetes develops.

The large group of obese diabetics in the early, reversible stage provides one of the most fertile fields for the practice of preventive medicine. Quite likely, in our present population, this group is the source of the largest percentage of hidden diabetics.

PREGNANCY HISTORY

The association of fetal abnormalities and pregnancy accidents with diabetes mellitus is generally accepted. Less well known, although recognized as long ago as 1928,⁹ is the possibility that such abnormalities may antedate the clinical appearance of diabetes by ten to twenty, or even thirty years.

In 1944, Miller, Hurwitz, and Kuder¹⁰ (reporting on a combined study at Yale University School of Medicine, Harvard Medical School and Cornell University Medical College) emphasized that fetal and neonatal mortality and the tendency toward

large babies were characteristics of the prediabetic pregnancy as well as the diabetic pregnancy. Since that time the subject of the prediabetic state, the fetal survival rate and the birth weight of the newborn child has been discussed in a number of papers.¹¹⁻¹⁴ New impetus was given to this problem by the report of Hoet¹⁵ who applied modern metabolic and hormonal studies in the clinical investigation of pregnancy in women and the experimental study of pregnancy in rabbits. Hoet regarded the permanent diabetes that develops in women in and after the fourth decade as the "culmination of multiple harmful events which have damaged the islands." In addition to such metabolic burdens as overeating and obesity, he felt that in the diabetically predisposed woman, pregnancy itself is diabetogenic. The cushingoid appearance of the plethoric, overweight infants led him to implicate the adrenal cortex and to conclude that "pregnancy is a physiological Cushing syndrome."¹⁶

In brief, Hoet emphasized that in susceptible women a transitory diabetes occurs during pregnancy because of a temporary state of hyperadrenocorticism. The pregnancy, in a sense, serves as a glucose tolerance test and provides an early clue to the development of diabetes mellitus many years later. On this basis, Hoet recommended a glucose tolerance test, or at least frequent urinalysis and blood sugar determinations, in all pregnant women with a family history of diabetes, or a history of miscarriages or stillbirths or large babies.

By the same token, in the search for hidden diabetes a careful pregnancy history should be taken from each married woman and a search for diabetes made whenever the pregnancy history reveals any one of these clues.

If pregnancy is diabetogenic, in the sense implied by Hoet, it is of some interest to speculate whether or not patients with numerous pregnancies might not have an increased tendency to diabetes. Recently, in an attempt to answer this, I carefully studied 50 women each of whom has had at least 10 pregnancies making a total of 610 pregnancies. Although not statistically valid because of the small size of the series, the results are shown in Table I.

What the factors may be that are involved here, I am not prepared to say. Undoubtedly they are multiple and probably obesity is significant. Nevertheless, for the purpose of the detection of diabetes, the woman who has had 10 or more pregnancies

should be considered a diabetes suspect until proved nondiabetic.

TABLE I
50 PATIENTS WITH AT LEAST 10 PREGNANCIES
TOTAL OF 610 PREGNANCIES

	POTENTIAL		
	DIABETIC	DIABETIC	NONDIABETIC
Total patients	27	9	14
Total pregnancies	349	106	155
Pregnancies per patient.....	13	12	11
Fetal and neonatal deaths.....	20%	17	23
Patients with at least one 10 pound baby	19 (70%)	5 (56%)	6 (43%)
Pregnancies with 10 pound babies	20%	28	10
Patients 20% overweight.....	85%	55	43%
Patients with diabetic family history	4	1	0

CORTISONE ADMINISTRATION AND SURGICAL PROCEDURES

Since pregnancy is considered diabetogenic because of its increased adrenal activity^{17,18} it is also important to seek hidden diabetes in other conditions in which adrenocortical activity is increased. The occasional occurrence of glycosuria in patients receiving cortisone, or related compounds, for therapeutic reasons is well known. Although on certain occasions this may be explained by a lowering of the renal threshold, the possibility must always be borne in mind that hyperglycemia may be an accompanying manifestation and that this represents the bringing to light of a potential diabetic state. In those rare instances in which apparently permanent diabetes has been precipitated by cortisone administration, the possibility must also be considered that the administration of the hormone was the final harmful factor which brought out the diabetic tendency. By the same manner of thinking, every patient receiving cortisone must periodically be tested for hyperglycemia, and the finding of such an elevated blood sugar must be considered a clue to a potential diabetic state no matter how transitory it may be.

Just as the exogenous administration of cortisone may be the earliest evidence of a prediabetic state, so the endogenous production of adrenal steroids under stress, such as a surgical procedure, may bring to light a diabetic tendency otherwise unrecognized. Adrenocortical activity is increased in the preoperative period¹⁹ and in the immediate postoperative period.²⁰ In view of this fact, every patient under-

going a surgical procedure should be tested preoperatively and postoperatively for glycosuria and hyperglycemia. It should be emphasized here that many a patient whose glycosuria in the postoperative period is casually explained by the infusion of glucose solutions intravenously may be a potential diabetic seeking to be recognized.

PREVIOUS GLYCOSURIA

Another possible source for the hidden diabetic is that group of individuals who at some time in the past (even on a single occasion) have been found to have glycosuria. Usually such individuals, either at the time of an insurance examination or on the testing at the time of presentation for examination by the Armed Forces, or just at the time of the first visit to a physician, are found to have sugar in the urine. Often these patients are rechecked at a later date, found to have no glycosuria, and are given no further attention. Unfortunately there has been a tendency to ascribe such transient glycosurias to emotional²¹ or renal factors.²² It is not so clear, however, whether or not the glycosurias appearing under emotional stress are entirely without significance. To put this to the test I have studied, during the last three years, an unselected series of 126 patients whose records showed that on a previous visit to the Lahey Clinic (usually the initial visit) a urinalysis had shown a "trace" or a "questionable trace" of sugar. A blood sugar determination one hour after oral administration of 100 Gm. of glucose was done in every instance in which the routine urinalysis was found to be free of sugar. The results of this study are shown in Table II. Of the 45 patients diagnosed as having diabetes, 20 were discovered from five to ten years and 10 of these over ten years after the recorded instance of transient glycosuria. The two commonest predisposing factors appeared to be a positive family history of diabetes mellitus and obesity.

TABLE II
126 PATIENTS WITH A PREVIOUS TRANSIENT MILD GLYCOSURIA

DIAGNOSIS	NUMBER	PER CENT
Diabetes (on insulin).....	18	14
Diabetes (diet alone).....	27	21
Potential diabetes	16	13

The results of this study would seem to indicate that the stress of an initial examination acted as a fortuitous test of potential diabetes in a significant

number of patients. It suggests that any individual who at any time shows a transient glycosuria, no matter how minimal, should be kept under observation as a diabetic suspect for many years.

FEBRILE CONDITIONS

Lukens²³ has called infection "nature's sugar tolerance test." He states, "Often fever taxes the function of insulin far more than 100 Gm. of glucose." The exact mechanism by which fever impairs the carbohydrate tolerance is unknown. Nevertheless, the fact that febrile states and infections with or without fever may greatly increase the demand for insulin, makes such conditions good tests of the insulin-producing capacity of the pancreas. Appropriate tests done under such conditions may uncover diabetic states that would not be apparent under normal conditions.

HYPERTHYROIDISM

Just as hyperactivity of the thyroid gland may accentuate the severity of existing diabetes, so also it may change a prediabetic to a diabetic state. This is demonstrated in Figure II which shows the increased frequency of mild diabetes in a hyperthyroid population.²⁴ That this results from overtaxing a pancreas with inherently limited capacity is suggested by the experiments of Houssay²⁵ in 1944 in which diabetes was produced in partially depancreatized but nondiabetic dogs by the administration of desiccated thyroid. If the thyroid was administered for a short period of time the diabetes was reversible on cessation of treatment. With prolonged administration, however, permanent diabetes resulted.

Hyperthyroidism, therefore, like fever, may serve as a glucose tolerance test.

VASCULAR DISEASE

The frequent association of vascular disease with diabetes mellitus is so well known that it scarcely needs to be mentioned. Less well known, however, is the fact that the vascular disease may appear before glycosuria.²³ A glucose tolerance test done on patients with vascular disease, when no glycosuria is detected and even when a fasting blood sugar is normal, will be an exceedingly enlightening and rewarding procedure.

In summary we may state that the hidden diabetic will be found among a group of individuals who show one or more of the following: a diabetic

family history, age over 50 years, obesity, poor pregnancy history or history of the birth of at least one 10 pound baby or numerous pregnancies, a history of glycosuria at any time in the past, fever, infection, hyperthyroidism, or if the patient is receiving cortisone therapy, or undergoing a surgical procedure.

DETECTION OF THE HIDDEN DIABETIC

The detection of the hidden diabetic calls for certain refinements of technic that are not necessary when a patient is initially seen with cardinal symptoms of the disease. Frequently, if not usually, a fasting blood sugar determination and urinalysis will be normal. The routine use of fasting studies probably is responsible for more missed diagnoses than is the mere failure to test at all. Furthermore, urinalysis alone is insufficient since in early diabetes the blood sugar may be elevated in the absence of glycosuria.

To overcome this error the minimum requirement is a urinalysis and a blood sugar determination performed one to two hours after a carbohydrate-rich meal. Many attempts to increase the accuracy of case finding have been suggested. The standard three hour glucose tolerance test is probably best but not always feasible. A urinalysis and blood sugar one hour after giving 100 Gm. of glucose orally, if the patient has not eaten for two to three hours, is relatively simple and more frequently possible. Fitcher and Suavé²⁶ have suggested a urine test done one and one half hours after the administration of 75 Gm. of glucose orally as a satisfactory screening test, and Engelhardt, Greene and Baird²⁷ have recommended a blood sugar determination after a breakfast plus 50 Gm. of glucose.

Further refinements are the cortisone-glucose tolerance test developed by Fajans and Conn²⁸ and the six minute glucagon-free insulin test of Anderson.²⁹ Probably more important than these interesting and possibly significant tests is the continued retesting of patients through the years with non-fasting blood sugar tests. It must be constantly borne in mind that the individual who has a normal test today may become diabetic tomorrow because of increasing age or the superposition of a diabetogenic stress factor.

To discover the hidden diabetic the physician must continue to search today, tomorrow, and everyday, and he must never be satisfied that he has

proved the disease does not exist in any patient who presents any of the clues suggested above. The bringing to light of the hidden diabetic provides one of the most challenging fields for the practice of preventive medicine that is known today.

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DRUG ADDICTION AND THE CANCER PATIENT

Anonymous

THE use of narcotics for relief of pain in cancer patients often causes unnecessary drug addiction. The misuse of addicting drugs usually results because of error in prognosis rather than error in diagnosis. Because of the low cost, ease of administration, and potent analgesic effect of addicting drugs, problems of tolerance and physical and emotional dependence may occur needlessly in patients who could possibly have several remaining years of social usefulness. The physician should, however, be cognizant of the difference between pharmacologic and psychologic need for addictive drugs. Serious and intractable drug addiction is usually a personality problem. A patient with an unstable personality may find the release provided by narcotics a pleasant solution to unendurable problems, and may become easily and quickly addicted. In contrast, the patient who has no emotional need to escape from reality and needs drugs only for pain relief, develops pharmacologic addiction much later and may never develop psychologic addiction. Modell has reported that cancer patients with intractable pain who received morphine for relatively long periods did not develop significant

tolerance and did not suffer withdrawal symptoms when the drug was withheld, after pain was controlled by other means. These patients had developed no emotional need for drugs, and the pharmacologic need was easily remedied. Obviously, even in instances of emotional dependence on narcotics, if the patient has advanced incurable cancer and intractable pain, the risk of therapeutic addiction is only of academic importance. It is equally obvious, however, that if a patient is known to be emotionally unstable or there is a reasonably long period of terminal care, the physician would do well to explore every other means of providing relief from pain. If narcotics are necessary, the minimal dosage that will relieve pain and maintain the patient in a functional condition should be employed.

Narcotic drugs are not a panacea for all types of pain in cancer patients. Hence, before opiates are prescribed, the possibilities of other palliative measures should be investigated. The patient may respond, for example, to neurosurgical intervention, nerve block, radiation therapy, or chemotherapeutic measures. The method of treatment should be determined by an evaluation of the pain, its degree

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of intensity, and its source and site. If at all possible, a planned program for relief of pain will have also the psychologic effect of providing hope for the patient. In addition, such a planned program is preferable to narcotic oblivion and loss of self-sustaining and productive living. False humanitarianism may result in stupefaction, respiratory depression, headache, anorexia, nausea and vomiting, and cachexia. Most important, premature use of narcotic drugs may result in rapid tolerance so that the patient cannot obtain adequate relief in the terminal stage even with massive doses of narcotic drugs.

In patients known to be terminal, the use of every effective palliative measure, is, of course, recommended. In such cases narcotic therapy may not only be necessary but also may be humane. If, however, the pain is mild, or appears to be partially a result of psychologic factors, and if the prognosis is favorable, the least potent analgesic capable of producing adequate relief should be used.

NONADDICTING ANALGESICS

Nonaddicting drugs with moderate analgesic effect include the salicylates, the coal tar derivatives, the antipyrine derivatives, and cinchophen. Combinations of this group of agents with barbiturates, caffeine, or codeine may often be used to greater advantage than the individual component. Tolerance will, however, develop to the analgesic effects of codeine so that the dosage of the latter may have to be increased in order to achieve the same amount of analgesia. According to Bonica, codeine with aspirin plus a nightly dose of a barbiturate may be useful in alleviating mild pain. There is, however, the risk of toxic reactions when these agents are used continuously. Moreover, the paraminophenols are habit-forming.

Among the general analgesics that are used for alleviation of pain are intravenous infusions of alcohol, local anesthetic drugs, and cobra venom. Ten per cent alcohol administered intravenously at the proper rate may relieve mild to moderate pain and provide mental relaxation without undesirable side effects. The administration should be closely supervised, and the rate of flow should be carefully regulated. Otherwise, there is a danger of the patient's becoming inebriated, overactive, and difficult to manage. Intravenous administration of procaine and related drugs is often ineffective, especially when given for the relief of pain that originates from the compression of nerves or obstruction of a viscus.

The efficacy of cobra venom remains equivocal. Prolonged periods of pain relief have been reported to result from daily use of venom, if treatment is maintained for as long as 30 days. However, Houde recently reported that trials with a purified preparation of cobra venom proved disappointing, and failed to confirm previous reports that this agent will reduce narcotic requirements.

ACTH and cortisone may produce euphoria; their pharmacologic effects, however, often limit their usefulness as analgesics. Chlorpromazine, although it possesses analgesic properties, is perhaps most effective in potentiating sedatives and narcotics. Finally, in the treatment of mild pain, placebos may also be effective.

PAIN

When psychologic causes are found to contribute significantly to the degree of expressed pain, the physician may aid in altering the perception of pain by modifying its central effects. This may sometimes be accomplished by the use of nonaddicting analgesics. Pain varies, however, in quality, intensity, site, distribution, and in cause. The degree may be determined by the mechanism by which cancer produces pain. For example, pain arising from necrosis, infection, or inflammation may differ from the sensations of discomfort from obstruction of hollow viscera. The perception of pain, moreover, is also a result of complex physiopsychologic processes. In this respect, the more maladjusted the individual was before the illness, the more psychotic will be his reaction to the disease process. Mental awareness of painful states may be determined, therefore, by personal and developmental influences. Consequently, the threshold of pain perception varies with each individual. A distinction should also be made between the perception of pain and tolerance of pain. Some patients may find pain of low intensity to be intolerable. In addition, the psychologic factors of pain may be affected by the patient's own attitude about cancer. Prolonged pain is, to a degree, caused by fear. The conscious sources include fear of continuing pain, of surgical mutilation, and fear of death. Fears that are less consciously realized include dependence, separation from family, or economic loss. Emotional reactions to fear commonly include anxiety, depression, guilt, hostility, and, occasionally, panic. Also, tensions, fears, and anxieties produce hyperactivity of the mechanism of pain reception. These reactions represent an effort of the patient to sustain the integrity

of personality under severe stress. Although psychologic reactions may contribute to the perceptions of pain, they should not be considered the cause when an organic basis cannot be found. An evaluation of pain as emotional in origin should be made only after a careful examination of the patient and appraisal of the personality.

WITHDRAWAL

If the patient becomes addicted to the use of narcotics because of an error in prognosis, an immediate withdrawal should be planned. The abstinence syndrome is, in its later phase, characterized by severe symptoms of physical dependence. There are also emotional reactions during withdrawal that are more individualized expressions of the patient's wish for relief. Abrupt and unaided withdrawal of opiate medication may therefore be agonizing and also dangerous to any patient addicted to narcotics. Symptoms may be alleviated, and permanent abstinence assured, by a systematic and controlled procedure of withdrawal and a close doctor-patient relationship.

The clinical management of the abstinence syndrome is always a highly specialized technique and should only be undertaken in a hospital. In general, the procedure consists of a transference to drugs which produce less severe symptoms of abstinence. Ordinarily cancer patients should not be subjected to the strain of a relatively rapid withdrawal.

PSYCHOLOGIC SUPPORT

Modification of the pain reaction in cancer patients before, during, and after withdrawal may be facilitated by psychologic support by the physician. This is true especially when the use of narcotics has become a form of emotional adaptation. The successful withdrawal of drugs, therefore, may not eliminate the fear or anxiety that preceded their use. A particularly important factor in the patient-physician relationship is the substitution of hope for fear. The patient should definitely realize the advantages of a return to a normal and constructive life without the use of narcotics. Hope should not be offered falsely, of course, and should have a basis

that can be subsequently tested and observed. The hostility that may result from the withdrawal of narcotics should be replaced by effort to increase the patient's sense of trust in the physician. Emotional dependence upon drugs, therefore, should be superseded by a degree of emotional dependence upon the sympathy and understanding of the physician. Although the patient with cancer may develop psychologic reactions specifically related to his disease, most often drug addiction is not originally a result of psychotic or neurotic disorders. Consequently, the prognosis of abstinence may be improved.

Subsequent physical manifestations may occur that can only be mitigated by a return to narcotic therapy. In such cases, or indeed in any cancer patient, the physician who prescribes narcotics should personally attend the patient. Also, the diagnosis of incurable disease and intractable pain should be confirmed by thorough examination. If narcotic therapy is necessary, addicting drugs should never be given the patient for self medication. Finally, and most important, all effective means of pain relief should be exhausted before resorting to administration of addicting drugs.

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THE ACUTE TOXICITY OF DORIDEN OVERDOSAGE

DONALD M. KANTER, M.D., *Stamford*

The Author. *Assistant Physician, Presbyterian Hospital, New York, N. Y.; Assistant Physician, Stamford Hospital, Stamford, Connecticut*

DORIDEN, alpha-phenyl-alpha-ethyl-glutaric-acid imide, is a sedative-hypnotic produced by Ciba, which has recently become a very popular "nonbarbiturate" on the pharmaceutical market. A review of the literature reveals no reports of the acute toxicity of this compound in man. The following case report illustrates some of the major toxic effects of an overdosage of this substance and the measures which proved of value in combatting them.

CASE REPORT

A postmenopausal, 53 year old, white, married woman who had had symptoms of a mild depression for several months swallowed twelve 0.5 Gm. tablets of Doriden at 4:15 P. M. on May 21, 1956. She had had an altercation with her husband and had consumed four or five glasses of beer prior to this.

PAST HISTORY

The patient had had a chronic bronchitis for many years. In 1948 a vaginal hysterectomy was performed in another city, following which she developed acute peritonitis and intestinal obstruction. With the aid of antibiotics, intestinal suction and supportive therapy she made an uneventful recovery. An appendectomy had been performed approximately 20 years ago. The remainder of the past history was noncontributory.

PRESENT ILLNESS

Within twenty minutes of taking the 6.0 Gm. of Doriden she became somnolent and soon thereafter unresponsive. Attempts by the family to arouse her were unsuccessful. At 5:30 P. M., one hour and fifteen minutes after the ingestion of the drug, she was admitted to the Stamford Hospital.

PHYSICAL EXAMINATION

The patient was a thin, chronically ill appearing female in a deep coma. Blood pressure 70/40; pulse 85 per minute; respirations 16 per minute; temperature 97.6. Head and neck: The eyes were wandering aimlessly and the pupils were in mid-dilatation, unresponsive to light; the fundi appeared normal. The neck veins were flat. Lungs: Coarse rhonchi were heard at both lung bases, but there were no signs of consolidation. Heart: Neither cardiomegaly nor murmurs were heard. Normal sinus rhythm was noted at a rate of 85 to 90 per minute and A_2 was louder than P_2 . Abdomen: Peristalsis was active and no distention or other abnormality was noted except for an appendectomy scar. Pelvic exam: Absence of the cervix and uterus was noted.

SUMMARY

A report of a patient who ingested an overdose of Doriden points out the relative short period of unconsciousness and the pronounced fall in blood pressure with very little effect on respirations. Delayed anticholinergic effects resulted, also a paralytic ileus, urinary retention, rapid heart action and pneumonitis. The successful treatment in this patient is outlined.

Rectal: Negative. Lymph nodes: None palpable. Skin: Flushed cheeks and moist skin were noted. Neurological examination: The patient was unresponsive and in a deep coma. The deep tendon reflexes were hypoactive and the extremities were flaccid. The superficial abdominal reflexes were absent and the Babinski sign was negative. The corneal and gag reflexes were absent.

COURSE IN THE HOSPITAL

The patient's stomach was suctioned repeatedly but only a small amount of the medication mixed with food was recovered. The blood pressure had fallen to 60/20 and a whole blood transfusion of 500 cc. of compatible Group O Rh positive blood was administered. This was followed by an infusion of Levophed (one ampule in 1000 cc. 5 per cent glucose in water). The blood pressure responded immediately to this therapy and levels of approximately 110/70 were sustained. Following the gradual tapering and final discontinuance of the Levophed infusion eight hours later the blood pressure remained at normal levels. Caffeine sodium benzoate 0.5 Gm. and ephedrine sulfate 25 mg.m. were given i.m. on admission and four hours later. At no time were the respirations depressed. The foot of the bed was elevated to 30 degrees and an airway had been secured from the outset.

Twenty hours after the institution of therapy the patient began to respond. The reflexes were then equal and active. Signs of pneumonitis at the right base appeared with respirations increasing to 30 per minute and the temperature varying between 100 and 103 degrees during the next four days. Patchy consolidation at the right lung base was confirmed by x-ray. Procaine Penicillin 400,000 units i.m. and streptomycin 0.5 Gm. i.m. were administered b.i.d. for one week.

On May 23, approximately 48 hours after the ingestion of the Doriden, the patient complained of inability to void; an indwelling catheter was employed with good output of urine. Concomitant with this, she developed a slow but progressive abdominal distention and complained of severe diffuse abdominal pain. Peristalsis was hypoactive. X-rays of the abdomen revealed a diffuse dilatation of the small intestine and colon; fluid levels and gaseous distention of the ileum were marked. A Miller-Abbot tube was passed and decompression begun. Several hours later the patient complained of substernal discomfort and auricular fibrillation at a rate of 130 per minute was noted and confirmed by electrocardiogram. 1.5 mgm. of Digoxin were given i. v. stat, and four hours later normal sinus rhythm was noted. Throughout this period the patient complained of blurred vision. The pupils were dilated. Dryness of the mouth was a minor complaint.

On May 24, three days after admission, the Miller-Abbot tube had advanced well into the small intestine and distention was definitely less. Prostigmine 0.5 cc. was given s.c. and repeated q4h for four doses. This resulted in passage of gas per rectum for the first time and thereafter decompression was rapid. Fluid and electrolyte balance were carefully maintained.

On May 25, four days after admission, she passed five loose stools. X-ray of the abdomen was normal at this time and the Miller-Abbot tube and the Foley catheter were removed. Progressive improvement in the pneumonic process at the right base was noted and at the time of discharge from the hospital on June 8, 1956 the patient was in good physical condition.

Laboratory data: May 22, 1956—white blood count was 6800 with 59 per cent polymorphs (8 bands), 38 per cent lymphocytes and 3 per cent eosinophils. Urinalysis: Yellow, clear; specific gravity 1.002, sugar negative, albumen negative, occasional R. B. C. per high power field (centrifuged). May 23, 1956, blood urea nitrogen 23 mgm. per cent. May 25, 1956, white blood count 6900 with 57 per cent polymorphs., 35 per cent lymphocytes, 3 per cent monocytes and 5 per cent eosinophils; hemoglobin 15.5 Gm., sodium 145 meq. per litre, potassium 4.7 meq. per liter, chloride 104 meq. per liter, CO₂ 24 meq. per liter. June 6, 1956 fasting

blood sugar 90 mgm. per cent; total protein 5.7 Gm. per cent, albumen 3.4 Gm. per cent, globulin 2.3 Gm. per cent, cholesterol 177 mgm. per cent, cholesterol esters 129 mgm. per cent; cephalin flocculation negative. June 7 and 8, 1956 gallbladder series negative; sigmoidoscopy to 22 cm. neg., barium enema negative, G. I. series negative, E. K. G. normal, chest x-ray normal.

DISCUSSION

Doriden is a potent sedative-hypnotic which in overdosage of the order of 6.0 Gm. (ten to twelve times the recommended dose) produces a deep coma. Extreme fall in blood pressure but little, if any, effect on respiration occurs. In this patient the duration of unconsciousness was relatively short as compared with overdosage of phenobarbital and other barbiturates. Anticholinergic effects, stimulating in many ways the action of atropine, are prominent but delayed; in this patient the paralytic ileus, urinary retention and rapid heart action were first noted forty eight to seventy two hours after the ingestion of the drug at a time when the patient had become responsive and alert. It is possible, but unlikely, that the patchy pneumonitis at the right lung base was the direct cause of the paralytic ileus; it may have contributed to the severity of this effect.

Passage of an intestinal tube for decompression and catheterization of the bladder are indicated. General supportive measures including strict attention to the patency of the airway and maintenance of fluid and electrolyte balance are essential.

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SPLENECTOMY IN FELTY'S SYNDROME

WILLIAM A. GEER, M.D., and ANDRAS E. LASZLO, M.D., *Bridgeport*

IN 1924 Felt¹ reported five cases of chronic arthritis associated with splenomegaly and leukopenia; and in 1932 Hanrahan and Miller² recorded the occurrence of remission of leukopenia in such a case after splenectomy. Hanrahan and Miller designated the combination of rheumatoid arthritis, splenomegaly, and leukopenia as Felt's syndrome.

A recent review of the literature by Fitzpatrick and Woodruff³ showed that forty-six cases of Felt's syndrome had been subjected to splenectomy, and in thirty-seven cases leukopenia was relieved after the operation. These authors reported one case, successfully treated by splenectomy. Subsequently Orebaugh and Coller⁴ reported eleven cases of Felt's syndrome treated by splenectomy with nine good results. Cole⁵ *et al.* in their review described eight cases of Felt's syndrome treated by splenectomy with four good results. Thus we have reports on splenectomy for Felt's syndrome in sixty six cases, in fifty one of which, or seventy seven per cent, the results were satisfactory. The following case is similar to the one reported by Fitzpatrick and Woodruff in that there was satisfactory response to splenectomy after failure of cortisone treatment.

Dr. Geer. *Associate Surgeon, Bridgeport Hospital, Bridgeport, Connecticut*

Dr. Laszlo. *Surgeon, Bridgeport Hospital, Bridgeport, Connecticut*

SUMMARY

A case of Felt's syndrome, successfully treated by splenectomy, is presented.

CASE REPORT

The patient was a woman of seventy-two years, born in Bohemia. She had a history of painful and deforming arthritis of several years duration. She was first admitted to the Bridgeport Hospital on September 15, 1947 complaining of painful and deformed hands and feet, malaise, and hemorrhagic spots on the legs. The spleen was not palpable. The blood count is recorded in the table. In the hospital she was given two blood transfusions, and discharged improved a week after admission.

On September 30, 1953 the patient was readmitted to the hospital with complaint of swelling of the face. Her rheumatoid arthritis had been treated with colloidal gold and Butazolidine. At this time the spleen was found to be enlarged to 4 cm. below the costal margin. Blood counts are shown in the table. She was given four blood transfusions. An examination of the sternal bone marrow was reported by Dr. Russell Pope as showing erythroid and myeloid

TABLE OF BLOOD COUNTS

DATE	MILLIONS HGB		W.B.C.	PLATELETS	TREATMENT
	R.B.C.	PER CENT			
September 15, 1947	4.7	55	2150	196,000	2 blood transfusions Colloidal gold Butazolidine
September 30, 1953	3.1	61	900	161,720	4 blood transfusions
October 26, 1953	3.8	74	2250	390,000	Cortisone, 1954 to time of splenectomy
September 5, 1955	2.8	49	1000	82,800	2 blood transfusions
March 29, 1956	3.6	57	750	195,480	4 blood transfusions
June 11, 1956		53	1100		2 blood transfusions
June 13, 1956	3.1	54	750	104,380	
June 18, 1956					Splenectomy
June 19, 1956	3.5	77	6050	177,000	
July 17, 1956	3.9	69	7600	180,000	

hyperplasia. She was again discharged as improved.

On September 3, 1955 the patient was admitted to the hospital with chills, fever, urinary frequency, weakness, and malaise. She had been getting cortisone 50 mg. daily for about one year, but her arthritis was not improved, and she did not feel stronger as a result of the treatment. She was found to have an infection of the urinary tract, and this was treated with urinary tract antiseptics. It was noted that the spleen was enlarged to four fingerbreadths below the costal margin. The blood count is recorded in the table. The Coombs test was negative. Examination of the sternal bone marrow showed evidence of erythroid hyperplasia. After receiving two blood transfusions the patient gained strength, and she was discharged from the hospital on September 17, 1955.

In March, 1956 the patient was admitted to the hospital with complaints of vomiting, weakness, and malaise. Another biopsy was done on the sternal bone marrow. Evidence of erythroid and myeloid hyperplasia was found. A diagnosis of Felty's syndrome with poor response to cortisone treatment was made, and splenectomy was advised, but the patient refused operation. She was given four blood transfusions and discharged improved.

Again in June, 1956 the patient was admitted to the hospital with complaints of vomiting, upper abdominal pain, weakness, and malaise. The spleen was found to be enlarged nearly to the umbilicus. The patient was given two blood transfusions. Dr. Nathan Friedman saw the patient in consultation. He concurred in the diagnosis of Felty's syndrome and advised splenectomy. This time the patient agreed to the recommendation of splenectomy. The operation was performed on June 18, 1956.

On the day before operation the patient received her usual doses of cortisone, 25 mg. in the morning and 25 mg. in the afternoon. A dose of 2 mg. Synkamin was given on the day before operation. In the morning, just before operation, a 50 mg. cortisone dose was given.

Ether anesthesia was given. The abdomen was opened through an L-shaped incision, starting at the xiphoid, extending down nearly to the umbilicus, then turning at a right angle to the left side and cutting across the left rectus muscle. The spleen was seen to be large, reaching almost to the umbilicus. The liver, stomach, and gall bladder were normal. Before the spleen was handled, the lesser sac was opened through the omentum near the greater curvature of the stomach. A large splenic artery, more than a centimeter in diameter, was found at the upper border of the pancreas. This large splenic artery was ligated in continuity with heavy catgut. Numerous fibrous adhesions between the spleen and the diaphragm were divided, and the spleen was gradually drawn out of its bed. While the spleen was being handled, it decreased in size until it was about one half as large as it was before the ligation of the splenic artery. The pedicle was then clamped, cut, and ligated, thus removing the spleen. There were no accessory spleens found. The abdominal wound was closed. No further blood transfusions were needed.

Immediately after the operation a dose of 100 mg. of cortisone was given, then 50 mg. cortisone each six hours for two days. On June 20 the dose was reduced to 25 mg.

cortisone each six hours, reduced to 25 mg. twice each day on June 23, further reduced to 25 mg. cortisone once each day on June 25, and on June 27 cortisone was discontinued. ACTH gel, 40 units, was given on June 23, June 25, and June 27. On June 29 ACTH gel, 20 units, was given. Thereafter no cortisone or ACTH was given. The patient made an excellent recovery. She gained strength rapidly, and felt greatly improved after the operation. She was discharged from the hospital in good condition on July 2, 1956. As indicated in the table, the leukopenia was relieved after the operation, and no further blood transfusions were needed.

COMMENT

Usually patients with Felty's syndrome have been treated with cortisone. Consequently, if splenectomy is to be done, it is vital that cortisone be used before, during, and after the operation. The need for cortisone decreases rapidly, however, after splenectomy. In many cases, in addition to improvement in the blood picture after splenectomy, there is also a beneficial effect on the arthritis. In order to explain the latter phenomenon, Steinberg⁶ presents evidence that there is hypertrophy of the anterior pituitary after splenectomy, which might lead to a stimulation of cortisone production.

The technic of splenectomy in Felty's syndrome must be gentle and precise, as in any sick patient with a large spleen. The method described by Singleton,⁷ using liberal exposure and ligation of the splenic artery in continuity above the pancreas preliminary to any handling of the spleen, is most satisfactory. When the spleen is handled after the artery is ligated, the spleen decreases greatly in size; thus the patient receives a large transfusion through the splenic vein just before the pedicle is clamped and cut.

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LABORATORY DIAGNOSIS OF CLINICAL TUBERCULOSIS

Comparing the Clinical Effectiveness of Culture and Guinea Pig Inoculation

PETER J. WICK, M.D., *Wichita, Kansas*

INTRODUCTION

The laboratory diagnosis of tuberculosis is based on demonstrations by a sufficiently sensitive test method that acid-fast tubercle bacilli are present and by a sufficiently specific test method that they are a virulent strain. Of the methods in general use, i.e., microscopy, culture, and guinea pig inoculation (GPI), the choice for clinical reliability depends on the relative differences in sensitivity primarily and in specificity secondarily. Because microscopy inherently lacks specificity and many factors easily affect its sensitivity, it is necessary to supplement it with either one of the others or both. Culture and GPI are both sensitive and specific but experiences with them differ so that they are variably used.¹ Culture is more widely used than is GPI¹ and is notably simpler, more rapid, and more economical. GPI is the accepted standard of specificity, although cultural characteristics combined with the neutral-red test closely approximate it for this use.² Whereas the major technical factors influencing these two methods have been studied extensively, comparisons of their sensitivity have been made infrequently. The few studies found indicate the paradox that, while experimentally the smaller number of organisms can be detected by GPI,³ under clinical conditions GPI and culture are equally effective.^{4,5}

There is always need to save time and money in the laboratory by replacing existing methods with equally effective but less costly ones whenever possible; if the less costly culture equals GPI in clinical effectiveness, it is desirable to replace GPI with culture. Because none of the encountered practical investigations correlates case studies to examine the relative sensitivity of these methods in detecting clinically positive cases, a survey of this hospital's experience was undertaken for this purpose and the results are presented and related under statistical control to economics.

The Author. *Formerly Resident in Pathology,
Norwalk Hospital, Norwalk, Connecticut*

SUMMARY

A study of 639 specimens, of which 592 were urines, correlating clinical and laboratory findings, indicates that the sensitivity of culture equals that of guinea pig inoculation (GPI) in clinical effectiveness and that GPI is superior to culture in specificity. It further indicates that in the important interest of economy of time and money in the laboratory, the use of culture should replace the use of GPI for detecting cases of tuberculosis and GPI should be reserved for use as a test for virulence of isolated acid-fast tubercle bacilli.

METHOD OF STUDY

Between March, 1950 and October, 1955 there were 2,187 miscellaneous specimens submitted to the Norwalk Hospital Laboratory for tuberculosis studies. The choice of test methods and the frequency of their performance per case were left to the preference of the submitting physicians. Of these specimens, the 639 subjected to all three methods in general use are the basis of this study; 592 of these were urines.* Each of these specimens was examined by microscopy and cultured routinely at this hospital on a single tube of commercial Petragnani medium. Neutral-red tests were not performed. The guinea pig inoculations were performed routinely in duplicate by the Bureau of Laboratories of the Connecticut State Department of Health on a neutralized concentrated sample of each specimen prepared at and mailed from this hospital.⁶

*Of the 1,548 specimens excluded for the lack of GPI studies, 53 (from 46 patients) were positive by culture. Only 124 of these were urines.

All cases from which specimens were reported positive by any of these methods were studied by clinical chart review and by follow-up contacts with patients or physicians whenever necessary. Cases in which the patients were established to have tuberculosis are classified as clinically positive and cases in which the patients were established not to have tuberculosis as clinically negative. Prematurely dead guinea pigs and contaminated cultures are designated as unsatisfactory results. Cases from which all specimens were reported negative by all three methods, with or without an unsatisfactory result, were not reviewed. These can be assumed to be clinically negative but are not so classified. All pertinent data are categorized and enumerated in tables for intra-subject comparisons.⁷

RESULTS AND COMMENTS

The GPI results are divided into three categories, i.e., positive, negative, and prematurely dead guinea pigs, and are grouped in Table I according to the results of culture, microscopy, and case review. The higher death rate among the animals (12.2 per cent) contrasts with the lower contamination rate in the cultures (7.8 per cent).

TABLE I
THE RESULTS OF LABORATORY STUDIES IN 639 SPECIMENS STUDIED BY ALL THREE METHODS

GPI RESULTS	CULTURE RESULTS			MICROSCOPY RESULTS		CLINICAL STATUS		
	POS.	CONTAM.	NEG.	POS.	NEG.	POS.	NEG.	NOT STUDIED
Positive (20)	16	0	0	10	6	16	0	0
	0	1	0	0	1	1	0	0
	0	0	3	0	3	2	1	1
Dead (78)	1	0	71	1	71	1	—	71
	0	0	6	6	0	1*	5†	0
Negative (541)	6	0	0	1	5	2	4	0
	0	3	0	3	0	0	3†	0
	0	0	11	11	0	1*	10†	0
	0	46	475	0	521	—	—	521

*Same case
†All were urine specimens

Table II is a reference table relating the specimens and the clinical status of the pertinent cases to the results of GPI, culture, and microscopy. Table III summarizes the results of these test methods relative to the 13 clinically positive cases as well as to the occurrence of the 23 false-positive specimens from that many individual cases found in this study.

GPI, culture, and microscopy show no appreciable differences in sensitivity or ability to detect

TABLE II
REFERENCE TABLE FOR CASE STUDIES AND SPECIMEN RESULTS

CLINICAL STATUS	GPI RESULTS			CULTURE RESULTS			MICROSCOPY RESULTS	
	POS.	DEAD	NEG.	POS.	CONTAM.	NEG.	POS.	NEG.
POSITIVE								
Total specimens	19	2	3	19	1	4	14	10
Case-Specimen								
A urines	8	0	0	7	1	0	5	3
urine	0	1	0	1	0	0	0	1
B urines	2	0	0	2	0	0	1	1
C gastric sputum	1	0	0	1	0	0	1	0
gastric sputum	1	0	0	1	0	0	0	1
D gastric	1	0	0	1	0	0	1	0
E gastric	1	0	0	1	0	0	1	0
F urine	1	0	0	1	0	0	1	0
G sputum	1	0	0	1	0	0	1	0
H urine	1	0	0	1	0	0	0	1
I urine	1	0	0	0	0	1	0	1
J gastric	1	0	0	0	0	1	0	1
K sputum	0	0	1	1	0	0	0	1
L gastric	0	0	1	1	0	0	1	0
M gastrics	0	1	1	0	0	2	2	0
NEGATIVE*								
Total specimens	1	78	536	4	49	562	18†	597
Case-Specimen								
N urine	1	0	0	0	0	1	0	1
O urine	0	0	1	1	0	0	0	1
P gastric	0	0	1	1	0	0	0	1
Q gastric	0	0	1	1	0	0	0	1
R gastric	0	0	1	1	0	0	0	1

*Includes cases not studied
†All were urine specimens

TABLE III
DISTRIBUTION OF CASES WITH POSITIVE SPECIMENS RELATED TO TESTING METHOD AND CLINICAL STATUS

TESTING METHOD	(SENSITIVITY)		(SPECIFICITY)
	13 CLINICALLY POSITIVE CASES		23 CLINICALLY NEGATIVE CASES (FALSE POSITIVES)
	DETECTED	MISSED	
GPI	10	3	1*
Culture	10	3	4
Microscopy	9	4	18*

*All were urine specimens

the clinically positive cases. Combined testing shows perfect results only because of the method of case selection. It is in the grouping of the false-positive results that any significant differences among the three methods become evident. Microscopy is seen to be most sensitive to error, culture less so, and GPI least. These results conform with previous observations. The significantly higher rate of false-

positive microscopy results illustrates the low reliability of this test method; that they are associated with urine specimens exclusively illustrates the need for wary interpretation and carefully complete investigation when such conditions are encountered. The false-positive culture results illustrates the need for testing positive cultures for specificity. It is important to note the single occurrence of error by GPI for it illustrates that technical factors found inherently and in routine clinical practice can even affect the specificity of this test method on occasion.

As indicated in Table IV the net effect of the 639 GPI studies, as well as of the 639 cultures, was to detect two cases but to miss three others.

TABLE IV

EFFECTIVENESS OF GPI AND CULTURE IN CASE DETECTION

Of the 13 clinically positive cases:

- 8 cases positive by both GPI and culture
- 2 cases added by positive GPI exclusively
- 2 cases added by positive culture exclusively
- 1 case added by positive microscopy exclusively

As regards economy, references to reliably accurate estimates of the cost of each guinea pig study per specimen performed by the State are not available. Since each guinea pig currently costs \$2.50 and estimates of monthly maintenance costs are as high as \$3.50 per animal, it is fair to consider \$15 a minimum cost for each guinea pig study per specimen when the two test animals are maintained for two months. Since one dozen tubes of commercial Pettragnani medium costs \$3.50 (about 30 cents each) and their maintenance cost is extremely low, it is certainly fair to consider \$1 a minimum cost for each culture per specimen. Ignoring that time and skill of performance add even more to the cost of GPI and applying these figures, the total cost of unsatisfactory results is \$1,170 by GPI and only \$50 by culture; the total cost of case detection by GPI

is \$9,585 and by culture only \$639. This clearly illustrates the economic superiority of culture over GPI.

In effect, the detection by GPI of each of the two cases missed by culture costs \$4,792.50. Because culture equals GPI in clinical effectiveness in this study, this cost per case is excessive. This particularly applies if it can be assumed that both missed cases might have been detected by a series of additional repeated studies by microscopy and culture. Had GPI been used solely as a test for virulence in this series and applied therefore to the 23 positive cultures exclusively, the total cost of GPI-testing would then have been but \$345 which is a far more reasonable figure.

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MEDICAL EDUCATION AND THE MEDICAL PROFESSION

ROBERT A. MOORE, M.D., *Pittsburgh, Pennsylvania*

JUST as there are dates and events which stand out as landmarks in the life of our Society and civilization, such as the birth of Christ, the signing of the Magna Charta, the Declaration of Independence, and the harnessing of atomic energy, so there are dates and events in the life of our institutions and individuals which were more important then and in memory.

Today is such a day in the life of the Hartford Medical Society and in the life of each physician of Hartford and through them to American Medicine. Already over a century old, medicine in Hartford and the Medical Society have made significant contributions. I refer particularly to the five programs of medical care in the community and of postgraduate education in the hospitals you have conducted for many years. It has been a model for others to copy and a place to which pilgrimages have been made to learn more and to imitate. Your members have not only given moral, but material support as witnessed by this magnificent new building, a visible expression of the position of medicine in the community.

CRITERIA OF A PROFESSION

Medicine is a profession and as we pause at this point in our institutional and individual lives, it is pertinent to examine what is meant by the word "profession." What is it that sets the professions apart from all other groups in our society? What characteristics are there of a profession, which make it distinctive and worthy of recognition? Many years ago Abraham Flexner outlined the criteria of the professions and they are as sound today as then. He included:

1. They involve essentially intellectual operations accompanied by large individual responsibility;
2. They are learned in nature, and their members are constantly resorting to the laboratory and seminar for a fresh supply of facts;

The Author. *Vice Chancellor, Health Professions,
University of Pittsburgh*

SUMMARY

There are certain criteria which differentiate the professions from all other groups in our society. To be regarded as professional one should be intellectual, investigative, practical, educational, group conscious, and socially minded. Because so much that pertains to health depends on many factors in the field of the social sciences the physician must of necessity be intellectual. It is impossible to separate the academician and the practitioner as both must be interested in investigation. Training for specialists and general practitioners alike should be practical. The full-time teacher in a medical school does not live in an ivory tower but, contrary to the belief of some, he is by necessity practical. There should be no gap between the academic teacher and the practising physician. Group consciousness is evidenced today by the development of postgraduate medical education. In a democracy such as ours American Medicine must be socially minded and must adapt itself to changing social needs.

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3. They are not merely academic or theoretical, however, but are definitely practical in their aims;
 4. They possess a technique capable of communication through a highly specialized educational discipline;
 5. They are self organized, with activities, duties, and responsibilities which completely engage their participants and develop group consciousness; and
 6. They are likely to be more responsive to public interest than are unorganized and isolated individuals, and they tend to become increasingly concerned with the achievement of social ends.

Presented at the Dedication Exercises of the Hartford Medical Society's new building, Hartford, Connecticut, September 13, 1956

April, 1957

Let me put these criteria into a few words—those who are to be regarded as professional are intellectual, investigative, practical, educational, group conscious, and socially minded.

If these be the characteristics which are desirable in those who work in a professional occupation, then we have an obligation to arrange our lives and our conduct so we measure up to them. Let us discuss briefly each of these basic attributes: intellectual, investigative, practical, educational, group conscious, and socially minded.

INTELLECTUAL

An intellectual person is one who possesses or shows intellect or mental capacity and the intellect is the power or faculty of the mind by which one knows or understands in contrast from that which one feels and that by which one wills. Intelligence is the capacity for understanding and for other forms of adaptive behavior, and aptitude for grasping truths, facts, and meaning.

Intelligence is an acquired characteristic and can be cultivated by study, reading, and discussion. Let me illustrate what I mean by a consideration of pre-medical education. All the health professions are closely related to the natural and physical sciences. In fact, I have said before that the medical sciences are actually only human biology and hence are really a part of biology, not just related to it. Therefore, many preprofessional students are so impressed with the importance of biology, chemistry, and physics that they attempt to advance their professional education by electing courses in these subjects in college. Let me cite a specific example. A young man is in a preprofessional medical course in college. In a given semester he has the right to select one three hour elective course. In the time available there are two choices, a course in general bacteriology or a course in history. Too frequently he says to himself, "If I take the course in bacteriology I will learn something I can use later, and if I do well in it, the Admissions Committee of the School of Medicine will be impressed because I know science." Less frequently and as I believe he should, he will say to himself, "When I am admitted to the School of Medicine I will take a course in bacteriology and I am sure they will cover everything I should know to be a good physician. But, I may not again have the chance to study history. If I understand history, I can better understand modern society, and if I have a sound grasp of modern

society, that will make me a better physician."

This example is not applicable to you who are now engaged in practice, but it does illustrate a broader concept.

In the twentieth century society is too complex for any individual or group to work in isolation only with its own specialized information. Health is no longer just a matter of the doctor's office and the hospital, and of the physician, dentist and nurse. The maintenance of health, prevention of disease, and cure of disease depend on many factors in the field of the social sciences. This is not the place to discuss such things as social security, disability benefits, hospital insurance, medical and surgical insurance, employee health benefits and the manifold health problems with social overtones, but it is the place to urge that the first characteristic of a profession—intellectual—be used in discussion and consideration of them; that is, that they be approached with the capacity of mind by which one knows or understands and by which one has aptitude for grasping truths, facts, and meaning, rather than by the capacity of mind by which one feels and wills.

INVESTIGATIVE

The second characteristic is investigative, meaning one who does investigation which may be defined as a searching inquiry in order to ascertain facts or a detailed or careful examination.

There has been a great deal of discussion in recent years that medical education is becoming too academic and that the full-time faculties of medical schools are too research minded or are too intent on investigation to the neglect of practice. Let us apply the approach of our first characteristic—intellectual—to a consideration of this problem. First, what is the basic purpose of medical education? Let me quote from a statement of the Association of American Medical Colleges.

"Undergraduate medical education must provide a solid foundation for the future physicians development. It should not aim at presenting the complete systematic body of knowledge concerning each and every medical and related discipline. Rather it should provide the setting in which the student can learn fundamental principles applicable to the whole body of medical knowledge, establish habits of sound and critical judgment of evidence and experience, and develop an ability to use these principles and judgments wisely in solving problems of health and disease."

As a physician myself I see no basic difference in the pursuit of a research problem in the laboratory and the examination of a new patient. Both involve the same mental processes and skills, to discover facts and draw deductions.

Some months ago a medical visitor from overseas was in my office. He had just come from another medical school which has instituted a new and different program of medical education. He said, "I was shocked to learn that it is possible for a medical student to graduate there and not to have seen a patient with acute appendicitis." He was also shocked at my answer: "I would not be too concerned about that omission. I know the students in that school are well informed on such principles as the reaction of the body to invasion by micro-organisms, the reaction of the peritoneum to irritation, and the localization of pain, and have been trained to examine the abdomen. Even if acute appendicitis were an unknown disease, these students could deduce that some tissue in the right lower quadrant of the abdomen close to the peritoneum had been invaded by micro-organisms."

Although we did not pursue the subject further, I could have pointed out that many students do not see an example of pyelphlebitis while in school, but I would be confident a student with a trained mind and a general knowledge of venous drainage and the complications of local infection would recognize it. If I had to choose between a student who learned soundly in anatomy about venous drainage and in pathology about infection, its effect on neighboring vessels, an infected thrombi and emboli, and a student who had seen a patient with pyelphlebitis, I would select the former as the better physician. What is the difference between acute appendicitis, pyelphlebitis, and hepatic abscess; and mastoiditis, jugular vein thrombosis, and lung abscess; and lung abscess, vertebral vein propagation, and brain abscess? Each one is simply a manifestation in one area of a fundamental principle.

On this basis I see no real difference between the academician and the practitioner. They are both interested in investigation, perhaps of different kinds, but still investigation. To attempt to separate the two groups, the teacher and the practitioner, is to set up a strawman.

PRACTICAL

The third criterion of a professional man is that he is practical. One definition of practical is, adapted

to actual use. This merely says that the ultimate objective of health care is the betterment of mankind; that medicine is a profession to be practiced; practiced with the attributes of intelligence and investigation.

One of the mistakes in much thinking today is that the four years of undergraduate medical education constitutes the education as it did fifty years ago. Medical knowledge, both theoretical and practical, has increased many fold in that half century and will increase many fold in the next half century. The mass of knowledge is already too great to be comprehended by one person, let alone by one person in four years.

The response to this increase in knowledge has been specialization, but there is a hangover of the older idea that the medical school still prepares general practitioners and residencies prepare specialists. The first fallacy in this viewpoint is that the general practitioner is not a specialist. In my judgment he is just as much a specialist as a surgeon or internist and he should be prepared for his specialty by residency training as rigorous as the others. The second fallacy in the viewpoint is that medical schools provide the knowledge for the general practitioner. Medical education should be pointed to providing the knowledge which all physicians should possess, whether they be general practitioners, specialists, teachers, or investigators. It is during the postschool period of residency and fellowship training that each group secures the specialized training for the field of its choice.

If I were a generalist and I am not, I am a specialist who believes in specialization, and who has been president of my own Board and president of the Advisory Board for Medical Specialties, I would not seek to set myself apart, but would drive for recognition as another type of specialist. To do this I would demand the same general type of residency training and perhaps I would take steps to form a Board which was as strict in its requirements and examinations as the other Boards. In other words, I would bring myself up to their level and join them, not fight them.

I believe that the future health care of the American people needs generalists as well as specialists, and I do not mean generalists without training beyond medical school and internship.

It is in this area that hospitals, particularly non-university hospitals with a local profession dedicated to education, have a real opportunity.

Another aspect of the criterion of "practical" which I wish to discuss with you is the current idea in the minds of many members of the profession that the teachers in medical schools are not practical. In a recent paper on this subject the author exaggerates to make a point: "On the other hand, the practitioner looks down patronizingly on the teacher as the dweller in an ivory tower, seeking a pleasant intellectual life remote from the pressures and problems of daily medical service, with which he is constitutionally unfit to cope successfully. This is a reflection of the old maxim: those who can, do; those who cannot, teach."

I do not wish to defend each and every full-time teacher in the medical schools, past and present, but I do wish to draw on my own experience to prove there is no "gap" between academic medicine and medical practice, or at least to attempt to decrease the size of the "gap."

If you accept that the practice of pathology is the practice of medicine, and I sincerely hope you do, then from graduation in 1928 until I became a dean in 1946, I practiced medicine as a full-time teacher as if I had not been a full-time teacher. During this time I was either assistant pathologist or pathologist to hospitals with from 600 to 1,000 beds. I did autopsies, I looked over surgical specimens, and I supervised other laboratory work. The only difference between my duties and those of the so-called practicing pathologist was that in addition to these responsibilities which both of us had, I had duties he did not have, viz., the responsibility of teaching a class, serving as a member of a faculty, and for part of the time administering an academic department.

And I know many, many other full-time pathologists and surgeons and internists who have had the same type of life and experience I have had. It is simply not true that the teacher lives a life "remote from the pressures and problems of daily medical practice" or is a "dweller in an ivory tower." And I can assure you that the life of a medical administrator is far from an ivory tower. Yesterday I participated in the opening exercises of a new medical school in New Jersey, and tomorrow I am to take part in a committee meeting in Chicago to plan the Second World Congress on Medical Education to be held in the United States in 1959.

EDUCATIONAL

The fourth criterion of a profession is that it is

educational. I have already discussed two aspects of medical education—the so-called premedical phase and the problem of principles versus facts. At this point I wish to consider another facet which threatens the entire fabric of medicine and medical education.

To introduce it, let me quote again from a recent paper. After setting forth the attitudes of the "academic teacher" and the "practicing physician," the author states "It is not surprising that there should be a gap between the two necessary components of the medical profession, . . ." In my opinion, quite the reverse should be our position; we should be surprised there is a gap in anyone's mind. Without the medical schools the profession of medicine would die out in one generation, and without the medical profession to serve as teachers the medical schools would disappear in less than a generation. If we were to concentrate on what we have in common and not on wherein we differ, we might be astonished. We are both interested in the welfare of the American people. We are both seeking new and better methods for the preservation of health and cure of disease. We are both devoted to the propagation of our species—the physician. We are like brothers in a family, both devoted to our family and to each other, but careful that one does not try to dominate the other. Each of us has a personality and freedom of action, so long as what one does, does not injure the other.

We respect the personality and opinions of the other. From time to time as brothers do, we may have wrestling matches or pillow fights, but just as brothers we are careful not to hurt each other, to create "gaps," or to leave scars.

GROUP CONSCIOUSNESS

The fifth criterion of a profession is group consciousness. More specifically in Dr. Flexner's words "a profession is self organized, with activities, duties, and responsibilities which completely engage their participants and develop group consciousness."

There could be no better example of this group consciousness than this building which we are dedicating this evening. Every physician should be a member of his county, state and national medical society and take part in its activities. It is only by participating that group consciousness can be fully developed for the good of everyone. Each person may not always agree with the action taken, but in a democracy there is never unanimity; if it were

otherwise it would not be a democracy. I have always admired the concept which is embodied in the phrase used in Britain—"Her Majesty's Loyal Opposition."

Also here in Hartford you have developed a group consciousness in the field of postgraduate education of which I have already spoken. Pittsburgh is proud of its ex-patriate, Dr. John Leonard who directs the program.

SOCIALLY MINDED

The sixth and final criterion of a profession is that it is socially minded. Again, to use Dr. Flexner's words, "it is likely to be more responsive to public interest than are unorganized and isolated individuals, and they tend to become increasingly concerned with the achievement of social ends."

Medicine, the medical profession, and medical schools are an integral and coordinated part of a complex modern society. We of medicine must find our niche in this society, but as society grows and changes, our niche changes and we must adjust our position. Our adjustment should be by leadership, not by following or by obstruction. Leadership implies affirmative action, not adherence to the status quo. It is possible that the status quo is the best solution, but this belief should be in the affirmative and not in the negative.

The need for numbers of physicians, for types

of physicians, for forms of treatment, for facilities for treatment are vastly different today than twenty years ago and will again be different twenty years from now.

Let me cite just one example. As the population ages the absolute and relative number of individuals over 60 will increase. Older individuals become ill oftener and remain ill longer than younger persons. This means more office calls, more home calls, and more patient days in a hospital. Older individuals suffer from more disabling conditions and have diseases in a different incidence than do the younger generation. All of this must be reflected in the educational program of medical schools, in the quantity and quality of health facilities, in the number and type of physicians, and in the provisions for the financing of health care.

I am satisfied that American medicine is socially minded and will make the necessary adjustments to meet the changing needs of society. Some may think we are moving too slowly or reluctantly, but again this is the way of democracy, a way which is far superior to that of a dictatorship of the proletariat, which today threatens a large part of the world.

I am honored that you have asked me to participate in the dedication of this new building for your medical society. I know you will with it and through it carry on the fine traditions of medicine in Hartford and in Connecticut.

A FABLE FROM DOCTOR AESOP

JOHN A. WOODWORTH, M.D., *Moosup*

ONCE upon a time there was a rooster who, having been born in Boston, considered himself endowed with particular knowledge and wisdom. And he became insufferable in the barnyard, ruling his roost with an arrogant pinion and wielding his spurs generously on all who sought to express differences of opinion.

Now it came to pass that this rooster was singled out for sacrifice to the festive board of the holiday season; and, after much flying about and scattering of dust and feathers, he was tossed across a chopping block and his head nearly severed by the blow of an axe. The rooster ran drunkenly into a forest where he soon lost his pursuers. Feeling however that something was wrong with his head, the rooster sought out a Young Doctor.

"Doctor," said the rooster, "there is something wrong with my neck, and I want you to diagnose and treat it."

"Of course," said the Young Doctor, "it is quite obvious that your head has nearly been chopped off. It needs to be sewed back on."

"Ridiculous!" scoffed the rooster. "That is impossible, and I do not believe you know what you are talking about."

"I advise you to have your neck fixed right away," admonished the Young Doctor, "else you will bleed to death."

"Pooh," replied the rooster. "You are too young to know the intricacies of my condition!" And the rooster staggered off to seek another doctor who practised in a larger city.

"Doctor," said he, respectfully, "I have a pain in my neck and wish to retain you to diagnose and treat me."

"Indeed," exclaimed the City Doctor, "you have come to me just in time. Your head has nearly been cut off and it needs to be sutured back on immediately!"

"Nonsense!" exclaimed the rooster, backing away, although appreciating the bigger words of the City Doctor. "You are incompetent, and although you are capable of taking care of the common cold, you are not in any case capable of sewing my neck back on. This is a matter of life and death and requires the skill of a more famous surgeon!" And despite the warnings of the City Doctor, the rooster ran off in all directions to find a Famous Surgeon.

Finally, the rooster arrived in Boston where he called upon a Famous Surgeon.

"Doctor," said he, bowing with respect, "I have a malady of the neck which is causing me great distress. I have come a long way to have you treat me."

"Ah," quoth the Famous Surgeon, grabbing up a needle and suture, "Your neck is half off. I will sew it back on immediately." And with great skill and precision, the Famous Surgeon soon had the rooster's neck sewed tightly back on.

But the rooster, having delayed so long in getting treatment, died as the last stitch was being placed.

Permission for autopsy was refused by the rooster's relatives.

Moral: A young general practitioner should not hesitate to call in a veterinarian.

ANNUAL COUNTY ASSOCIATION MEETINGS

New Haven, Thursday, March 28

WAVERLY INN, CHESHIRE

Business meeting: 4:30 P. M.

Dinner: 7:00 P. M.

Speaker and subject to be announced

Hartford, Tuesday, April 2

HARTFORD CLUB, HARTFORD

Business meeting: 4:30 P. M.

Dinner: 7:00 P. M.

Speaker: The Reverend Donald Harrington

Subject: "THE DOCTOR'S ROLE IN INTERNATIONAL AFFAIRS"

New London, Thursday, April 4

NORWICH INN, NORWICH

Business meeting: 4:30 P. M.

Dinner: 7:30 P. M.

Speaker and subject to be announced

Fairfield, Tuesday, April 9

STRAITFIELD HOTEL, BRIDGEPORT

Business meeting: 4:30 P. M.

Dinner: 7:00 P. M.

Speaker and subject to be announced

Middlesex, Thursday, April 11

ELKS CLUB, WESTBROOK

Business meeting: 4:30 P. M.

Dinner: 6:30 P. M.

Speaker: Mrs. Casto L. Caiazza

Subject: FOREIGN TRAVEL

Tolland, Tuesday, April 16

OLD HOMESTEAD INN, SOMERS

Dinner: 6:30 P. M.

Speaker and subject to be announced

Litchfield, Thursday, April 18

CONLEY INN, TORRINGTON

Business meeting: 5:00 P. M.

Dinner: 7:00 P. M.

Speaker: Mr. George Z. Denny, Jr., Former Radio Moderator of Town Hall of The Air

Subject: "PEOPLE TO PEOPLE"

Windham, Thursday, April 18

BEN GROSVENOR INN, PONFRET

Dinner: 6:30 P. M.

Speaker and subject to be announced

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

We Cross the River

Only once in the last 100 years has the State Medical Society crossed the Connecticut River to hold its annual meeting. In May, 1863 Rockville was the host to the Society. Just where in Rockville the meeting was held the record does not show, but we do know that at the close of the first day's sessions "an invitation from Dr. Goodrich to spend this evening sociably at the Rockville Hotel, as guests of the Tolland County Medical Association, was accepted."

The scientific program of that meeting 94 years ago bears little resemblance to the 1957 edition. The address of the retiring president, Josiah G. Beckwith of Litchfield, was entitled "The Medical Profession—Its Dignity and Grandeur." It was a solid potion for any body of men to absorb, covering 23 pages in the Proceedings. Following that there was the Annual Dissertation, this time on "Logic Applied to Medical Science" and read by James C. Jackson of Hartford, and "Vindication of Army Surgeons" by Ashbel Woodward, Surgeon, 26th Regiment, Connecticut Volunteers. Finally, Moses C. White of New Haven reported "An Anomalous Surgical Case, in which a nail broken off in the foot separated into twenty-six splinters which were successfully removed after intense suffering."

Contrast the foregoing with the East Hartford program in which appear such topics as "Tranquilizing Drugs," "Medical Care Insurance," "The Lung Cancer Problem," "Vascular Emergencies," to name but a few. If, as Sir William Osler has said,

the education of the physician is a life course, no member of our Society who is physically able to be carried across the River in this day of easy transportation or who can stop long enough to drive in from nearby Tolland or Windham County or up from New London County can afford to miss the attractive and rewarding program which the committee has laid out over the two days allotted to the annual meeting.

Crossing of the Connecticut River in itself poses no great problem today. Even though traffic over the Charter Oak bridge and the Bulkeley bridge at Hartford is congested during rush hours, there is the Middletown-Portland bridge and a promise of three more bridges in the vicinity of Hartford in the near future, one nearing completion at this moment. Crossing the Connecticut was not such a simple matter in 1863. In place of the two ferries which formerly operated between the Hartford and the East Hartford shores, there was a covered wooden bridge requiring payment of a toll. But during the spring freshets it was necessary to ferry vehicles and passengers from the East Hartford end of the bridge across the submerged meadows to higher ground. The melting snow and ice probably had gone their way to the sea by the latter part of May, 1863 so that with a good horse and buggy the wooden toll bridge sufficed for a safe crossing.

East Hartford offers no problems of access in 1957. Highways north and south, east and west, are built for speed. No ferry will be required in crossing the river and the toll of a few pennies on the old wooden bridge has now been done away with on

its successor, Bulkeley bridge. True, Charter Oak bridge extracts a 15 cent toll, but who would object to that with such an intellectual feast awaiting on the East Hartford shore?

The Education of the Physician

"Good medical education is nothing more than good education." In making this statement Dean Berry of Harvard Medical School points up the fact that medical education cannot be divorced from the broad field of education which is producing so many problems today. One need only take cognizance of the fact that during this calendar year a series of five regional conferences will be organized for the purpose of bringing together groups to discuss post-high school education. These conferences will emphasize the relationship of this subject to the national welfare, will propose recommendations, and, like the pattern in every other field of endeavor, will attempt to determine what part the Federal Government should play in relation to education beyond the high school level.

"The doctor has become more than doctor. He is doctor and sociologist, scientist and humanist, investigator, administrator, psychiatrist, wise man, philosopher and friend. And more, perhaps, than these." If we subscribe to these words of the president of Harvard University we must admit that a broader education for the physician of the future is important, and because of its growing complexity this education must begin early, at least at the start of the academic program.

Experiments to discover better ways of teaching medicine are undergoing trial. Complete answers to the many problems involved, although being sought, may never be found but, as President Pusey has said, "what is sought today is not the stuffed head but broad interest and awareness, and with these an informed and inquiring mind."

If the estimates of the increase in numbers of those who will seek admission to institutions of higher learning are correct, increasing pressure will be brought to bear on the ones who make the selections for admission to medical schools. One university educator has predicted that medical educators will have to enlist the aid of psychologists and sociologists in selecting the higher type of students for medical school admission.

The problem does not end there, however. Two facts stand out as one surveys the results of our

present medical education program: first, that the medical school curriculum is becoming so crowded with the addition of important subjects that deans are fast growing gray in their efforts to find the correct solution; and second, that because the pre-medical education of many physicians during the last half century has neglected the humanities we have produced a brand of doctors who are not educated. Medical editors in particular are keenly aware of this latter fact.

What is the answer? If there is one it is not easy to find. Specialization has advanced to the point where the boundaries of the known in the old subjects have been extended and almost endless new subdivisions have sprung up. Of equal importance is the difficulty arising from the widening conception of what is relevant in medical education. One solution has been offered by a group at the University of Pittsburgh. They would divide the education of the physician into three stages of three years each. The first three years would be devoted to premedical, that is, college or university training. The second three years would be spent in formal medical school classroom instruction. The third three years would find the neophyte physician working on the hospital wards and in the outpatient department. The advocates of this plan feature the fact that it allows for a continuation of study in the humanities and social sciences during the medical school years "in an effort to turn out educated doctors rather than narrowly trained specialists."

Our Pittsburgh friends may be a bit idealistic in believing that the medical student, with a three year curriculum, is going to continue his pursuit of the humanities. The urge to do this must come in college days, or even before, and unless one has become interested in a liberal education in preparation for professional training one scarcely will create such an interest when the days are crowded with courses in anatomy, bacteriology and pathology. Turning to the plan for spending three years in hospital internship, much can be said in its favor as a preparation for general practice and as an improved background for the specialist. But it is doubtful if the surgeon will spend three years in a general internship, and then add the years of training now required to qualify him for the specialty board.

The entire problem of education, not alone medical education, is in a state of flux at present. There are those who cry out that the study of the sciences is being neglected in our high schools resulting in

illiteracy in one field of knowledge. There are others who feel that the humanities are being neglected, especially in the college and university undergraduate years. The arrangement of the medical school curriculum is under critical scrutiny as many would add instruction in new fields related to clinical medicine.

The last week of this month has been designated as Medical Education Week. It is fitting that we as mature citizens as well as devoted physicians should direct our attention to this part of our professional life. We are aware that unless we have cultivated habits of study in our earlier years we will find that continuing study, a necessity for a successful physician, will be difficult to carry out and as a result our education will be limited. It is fortuitous that we are able to offer to our readers at this time some of the thoughts on medical education by one of its leaders, Dr. Robert A. Moore of the University of Pittsburgh. Dr. Moore outlines the requirements a physician should fulfill if he is to be truly a member of a profession.

"The hardest conviction to get into the mind of a beginner is that the education upon which he is engaged is not a college course, not a medical course, but a life course, for which the work of a few years under teachers is but a preparation." (Osler.)

Infertility

Until recently the infertile couple was considered to have a hopeless and insoluble problem. For such individuals the most practical advice was often to adopt a child and then "have one of your own." During the past twenty-five years however a tremendous amount of investigative work has been done on the subject as is evidenced by the excellent summary on "The Causes and Treatment of Infertility" which appears in this issue of the JOURNAL.

Such studies have been related usually to the more obvious anatomic and endocrine factors involved, with particular reference to seminal, tubal, cervical and ovarian abnormalities. In about fifty per cent of those couples the desired result—a pregnancy—has been achieved and it has seemed natural to credit investigation and advice for this. Only recently has there been a tendency to question the importance of the role of somatic therapeutics in the achievement of conception.

At present it seems fair to state that in only three ways is the infertility study of definite benefit to

the couple involved. These are: (1) Positive information to those unquestionably, permanently, and anatomically infertile. This understanding may enable the couple to attain happiness through earlier adoption. (2) Correction of anatomic defects which definitely preclude conception but are surgically amenable to alteration. (3) Encouragement to the couple who have not achieved pregnancy but in whom no definite bar has been found. This last group is the most numerous and it is now realized that here psychic factors are undoubtedly of the utmost importance. It seems probable that the soundest advice which the gynecologist can give such individuals is to consult a competent psychiatrist.

A New Era in Diabetes

Since early detection of chronic illness and the prevention of the complications of chronic illness are every physician's prime interest, the article by Dr. Murphy in this issue is of particular importance. There is no branch of medicine which does not include treatment of diabetes or one of the many severe complications of diabetes. The surgeon is confronted with "diabetic gangrene," the obstetrician with the diabetic mother and the problem of increased fetal mortality, increased incidence of toxemia and the peculiar problems of diabetic control. The medical man must cope with complicating heart disease, renal disease and vascular disease as well as controlling the diabetic state. Since the major goal now is control and prevention of the myriad complications of diabetes, it is hoped early detection and treatment will make this more easily attainable.

We are entering a new era in the understanding of diabetes. With the discovery of the hypoglycemic action of certain sulfonamide derivatives and the clinical application of these compounds, it is hoped many of the riddles of this illness may be solved. We are witnessing just such a development with cortisone and its derivatives and the physiology of adrenal gland.

Constant vigilance by the physician and the application of new principles of detection and control should give the diabetic patient even greater relief from his illness and its complications.

Doctors as Collectors

What doctors do when they are not doctoring is obviously their own business but sometimes that

business is surprisingly interesting and important. This is true for those physicians who collect memorabilia relating to medical history, the importance of which needs no further comment. Connecticut doctors have long had an interest in the cultural aspects of their own and other times. Many of our earlier doctors were renowned as classical scholars and some contributed to our National literature. Our libraries and museums have benefitted greatly from the collecting activities of our doctors. The Steiner Collections at Hartford and Baltimore, the Hallock Collection at Wesleyan, the Cushing and Fulton Collections at Yale are widely known. The names of other Connecticut doctors associated with important collections are many. One recalls S. C. Harvey, E. C. Streeter, C. C. Fry, J. E. Lane, G. M. Smith, H. B. Ferris, among them.

Doctors as Collectors is the theme of an exhibit at the Yale Medical Library and these, our colleagues, are here represented: Creighton Barker, Early Medical School Catalogues and Pamphlets; Maurice J. Strauss, Commemorative Medical Stamps; William Finkelstein, Medical Autographs; Ernest Sachs, Sir Victor Horsley Memorabilia; Everett S. Rademacher, Private Proprietary Medicine Stamps; Herbert Thoms, J. G. Percival Memorabilia; Richard D. Otis, Medical Course Admission Cards.

The Medical Library hopes that this exhibit will stimulate other medical collectors to reveal their talents and that other exhibits will give us a similar opportunity to view the fruits of their acquisitiveness. The Yale Exhibition ably supports a revision of an old saw, to wit, Doctors are Notoriously Good Collectors.

Pure Food and Modern Living

*"Now good digestion wait on appetite, and health on both."
Shakespeare. Macbeth*

There are three main factors which have influenced the development of changes in our food habits as compared with those of our forebears of a couple of generations ago: (1) the increasing shortage and cost of domestic help; (2) the production of processed foods in various forms planned to make it easier for the housewife to prepare meals; and (3) the use of chemicals as parasiticides in the growing of some fruits and vegetables and as additives to foods to retard oxidation, increase nutritive value, preserve color and flavor, and promote edibility.*

The increasing shortage of domestic help is a reflection of the growing employment of women in more and more occupations that once were traditionally closed to them. This situation no doubt has been aggravated by inflation and the accompanying rise in the cost of food so that nowadays it is not uncommon in families for both husband and wife to be gainfully employed.

The use of processed foods, while indubitably making the work of the housewife easier, raises questions bearing on the health of individuals who consume them. Does the processing impair the nutritive value of the food especially as regards its vitamin content or chemical constitution? The subject is a complex one. In some processes, such as the manufacture of white flour, vitamins are removed and later artificially replaced. In other cases vitamins may be added to foods not very rich in them. Improper cooking, especially overcooking of vegetables, may leach out vitamins which are then poured down the sink in the cookingwater.

The complete removal of insecticides and fungicides used to reduce pest damage to growing food crops may be very difficult and, as one well known commentator recently remarked over the radio, we probably all get a nontoxic dose of DDT with our dinner. Whether such a dose absorbed for years produces untoward effects is not known.

However, as Robert R. Williams of the Research Corporation has pointed out, we are better protected from food adulteratives, poisons, and deficiencies than ever before.† The administrators of the Federal Food and Drug Administration have been, from its inception in 1938, men of the highest integrity, and they cooperate fully with two other organizations: the Food and Nutrition Board of the National Research Council, and the Council on Foods and Nutrition of the American Medical Association. The processors of food have also been cooperative. While the nutritional needs of mankind are far from being as simple a problem as was once conceived, we can feel confident that careful studies are continually being made by all these agencies, and that in time the kinks will be finally straightened out.

G. B.

*Editorial on Chemicals in Food, C. N. Frey, Science 1954, 120:7A.

†Williams, Robert R., Science, 1954, 120:473.

PROGRESS IN CLINICAL MEDICINE

THE CAUSES AND TREATMENT OF INFERTILITY

LUIGI MASTROIANNI, JR., M.D., *New Haven*

The Author. *Assistant Professor, Department Obstetrics and Gynecology, Yale University School of Medicine*

THE causes of human reproductive failure and their treatment have received increasing attention in the last quarter century. Infertility, once regarded as a diagnosis per se, has assumed its rightful place as a symptom, reflecting derangements in the anatomy and physiology of the male and/or female reproductive tracts. The known causes of sterility are multiple, and the problem must be approached systematically. Minimal standards for an infertility investigation have been recommended by the American Society for the Study of Sterility.¹ These include evaluation of seminal, tubal, cervical and ovarian factors. It is generally agreed that such an investigation is in order if conception has not occurred after a year's unimpeded exposure. Statistical data on normal fertility support this view.^{2,3} We propose to review the currently available diagnostic and therapeutic methods in human infertility.

THE MALE FACTOR

Before embarking on an extensive diagnostic study of the female, assessment of the male's reproductive potential is mandatory. When insemination is adjudged adequate through the postcoital test, to be described below, the husband may temporarily be assumed to have sufficient sperm production. If the postcoital test is less than fair, examination of the male with attention to the urogenital system becomes essential. Sperm analysis is an integral part of the evaluation. The specimen is collected into a clean, dry jar and delivered to the laboratory as soon after as practicable. When collection into a condom is preferred, one of plastic or nylon must be used, as most commercial rubber condoms contain spermicidal agents. The patient should be cautioned to be sure to include the first portion of the emission, as 75 per cent of the spermatozoa are located in the first 40 per cent of the ejaculate.⁴ The relatively infertile male suffers a pronounced reduction in sperm population by frequent ejaculation.⁵

SUMMARY

The techniques in the diagnosis and treatment of human infertility have been reviewed. The ultimate goal of the physician is not merely that of a successfully terminated pregnancy. Equally important is his ability to offer the couple a prognosis to permit intelligent planning of their lives and perhaps earlier consideration of adoption. There are still large gaps in our knowledge, and it is often difficult to prognosticate in the individual case. Treatment of male infertility remains discouragingly unrewarding. There has been some improvement in our approach to the problems of anatomical tubal pathology and in the diagnosis and treatment of ovarian dysfunction. The need for continued basic research in the physiology of reproduction is evident.

Four or five days of abstinence prior to collection are therefore recommended. In order to evaluate the usual characteristics of the ejaculate for the individual couple, this interval may be decreased to the accustomed period of time between coitus for that couple.

The specimen is analyzed as to its volume, sperm concentration, quality of and percentage of motility, and percentage of abnormal forms. Of these, sperm density and motility are of greatest prognostic significance. In the past, 60 million spermatozoa/cc. was thought to constitute the lower limit of normal for fertility, and this figure is still advocated by some as a minimal standard.^{6,7} Recently MacLeod has reported convincing data which would place the lower level at 20 million/cc.^{8,9,10} There is pronounced impairment of fertility when repeated specimens display a motility of under 40

per cent or when the quality of sperm motility is consistently poor.⁹ Because of the known variability in sperm quality from one collection to the next,¹¹ assessment of the status of the male should never be based on a single semen analysis. It is known that males with counts under 20 million/cc. still have some fertility potential, and save when there is persistent azoospermia, the physician must exercise caution in tendering a diagnosis of absolute sterility based on semen analysis.

The physical examination sometimes discloses anatomical abnormalities which explain decreased sperm production. Among these are cryptorchidism, testicular atrophy and significant varicoceles. A history of mumps orchitis or gonorrhea provides a clue to the source of the difficulty. Occasionally, following herniorrhaphy, the vascularity of the testicle is impaired and its function disturbed. Cases with apparent azoospermia, albeit rarely, have been found to suffer from retrograde ejaculation into the bladder.¹² The diagnosis is made by examination of the urine for spermatozoa immediately following orgasm. More often than not, careful study notwithstanding, the etiology of spermatogenic difficulties remains inexplicable. Treatment is still discouragingly unsatisfactory. In those cases with ductal occlusion an attempt to re-establish patency surgically may be justifiable, provided there is evidence of continued spermatogenesis on testicular biopsy. Some success has been reported with newer surgical approaches to this problem.^{13,14} For retrograde bladder ejaculation, artificial insemination with spermatozoa obtained from the urine should be tried. Medical treatment of oligospermia is of decidedly limited value. The empirical use of thyroid extract is useless, and thyroid should be reserved for those patients with proven deficiencies.¹⁵ Currently available gonadotrophin preparations have been shown to be ineffective.¹⁶ The occasional oligospermic male responds to suppressing doses of testosterone by a rebound in sperm production above previous levels following cessation of therapy.^{17,18} The criteria for the use of androgens have not been established, and the results of such therapy are neither consistently good nor predictable.¹⁹ Measures to improve general health, such as correction of anemias, improved diet and weight reduction are thought to be generally beneficial and are recommended for want of anything better. Artificial placement of husband's sperm has been used in cases of oligospermia with a view to

improving insemination. Whitelaw has suggested that the specimen be held in reasonable proximity to the cervix with a paracervical cap.²⁰ Others have reported, however, that artificial insemination with oligospermic specimens, regardless of the method used, is invariably unsuccessful.^{21,22}

Examination of the male partner is often helpful even when sperm production is considered to be adequate. A hypospadias, for example, could easily result in loss of the greater portion of the ejaculate during intercourse. Frank discussion in private may uncover sexual difficulties such as premature ejaculation or even impotency which the female partner may find difficult to discuss. The diagnostic importance of the postcoital test in these situations is obvious.

THE POSTCOITAL TEST

As early as 1866, J. Marion Sims described the postcoital test and stressed its usefulness in infertility studies.²³ The technique of the procedure involves the removal of a sample of cervical mucus for examination. For this, a simple aspirator, a nasal polyp forceps or a fenestrated intestinal forceps are convenient instruments. The test should be scheduled in the menstrual cycle at or just prior to the expected date of ovulation. It may be routinely performed up to 18 hours after intercourse. In fact, motile spermatozoa have been observed in cervical mucus as long as six days following the last coitus.²⁴ Insemination may be adjudged adequate when at least 10 to 20 spermatozoa are seen in each high power microscopic field. Since not enough is known about the statistics of sperm penetration, absolute standards for the postcoital test are probably not within the realm of possibility. In fact, among 70 postcoital tests following which conception occurred in the same cycle, Southam and Buxton found only an occasional motile spermatozoa or none in 27.²⁵ In addition to giving information regarding cervical insemination, the postcoital test allows an evaluation of the quality of the cervical mucus in the ovulatory phase. Normally there is a variation in the characteristics of the cervical mucus during the menstrual cycle. Early, it is scanty, viscous and cellular. As ovulation time approaches, it becomes more abundant, thinner and clearer. Its ability to form a thin, continuous thread when spread, so-called "Spinnbarkeit," is enhanced. These physical characteristics of ovulatory mucus are associated with increased receptivity to sperma-

tozoa,²⁶ and have been reproduced in castrates by the administration of estrogen.^{27,28} In the postovulatory phase the mucus becomes opaque, tenacious and cellular once again and is less receptive to spermatozoa.

Because the quality of cervical mucus is not constant in the menstrual cycle, a diagnosis of defective mucus must be confirmed by several examinations during the ovulatory phase. In an occasional patient the mucus does not at any time take on the characteristics which are associated with sperm receptivity, i.e., it remains scanty, viscous, opaque or cellular. Such a condition sometimes, though not always, is associated with gross evidence of an endocervicitis. Treatment with judicious cauterization or cervical culture followed by local and systemic treatment with the appropriate antibiotic may bring about improvement.²⁹ That this approach is no panacea has been pointed out by Buxton *et al.* who, in a large series of cases, found no difference in the rate of conception between treated and untreated groups.³⁰ Estrogen in small dosages (0.1-0.3 mg. of diethylstilbestrol or its equivalent) sometimes influences the production of a more favorable medium for sperm. When small amounts of estrogen are ineffective, a larger dosage may be tried. Usually, however, the larger quantity inhibits ovulation, defeating the primary purpose of therapy.

Inadequate insemination may be the result of incomplete penetration during intercourse. Examination may reveal anatomical abnormalities to account for this which, in the extreme cases, take the form of an intact hymen or a greatly contracted introitus with a rigid perineal body. By treatment over a period of weeks with graduated vaginal dilators and frequent consultation visits, normal coitus is usually initiated.³¹ Not uncommonly the history discloses that the patient has been in the habit of rising from bed or even douching immediately following intercourse. Proper advice on such matters is invaluable.

TUBAL FACTORS

It has become increasingly clear that the function of the Fallopian tube in reproduction is more than that of a passive transporting passage. There are variations in endosalpingeal morphology^{32,33} and in vitro physiological activity^{34,35} in the menstrual cycle, and it is tempting to relate these changes in some way to tubal function. The work of Shettles hints strongly that the tube plays an important role

in the actual process of fertilization.^{36,37} The process of ovum transport is an active one, and the fimbria are thought to embrace the ovary during ovulation.^{38,39}

Much is known about anatomical abnormalities of the Fallopian tube, but disturbances in tubal physiology remain matters for conjecture. Anatomical derangements are invariably the result of inflammatory processes, either within the tube per se or in the pelvic area immediately surrounding the tube. Gonococcal or puerperal pelvic inflammatory disease, though less common since the availability of antibiotics, are still major causes of tubal pathology resulting in sterility. Their relatively decreased incidence has focused increasing attention on pelvic tuberculosis. Sharman reports genital tuberculosis in 5.2 per cent of infertility patients in England.⁴⁰ The tubes are reported involved in 90-100 per cent of cases of genital tuberculosis.⁴¹ The endometrium is affected in about half, and unsuspected pelvic tuberculosis is frequently uncovered by endometrial biopsy. A history of appendicitis, especially when there has been rupture with peritonitis, should alert the physician as to the possibility of peritubal adhesions. Diverticulitis, previous pelvic surgery and endometriosis can also be responsible for adhesions involving the tubes.⁴²

Tubal insufflation, first described by Rubin in 1920,⁴³ has retained an important place in our armamentarium. Carbon dioxide is now the gas of choice, air having been abandoned because of the danger of embolization. The gas is introduced into the uterus at a pressure which is not allowed to exceed 200 mm. of mercury. When there is patency of at least one tube, the gas escapes into the abdominal cavity. When the patient assumes the upright position, it rises to the diaphragm, irritating the phrenic nerve and causing referred shoulder pain. Tubal patency cannot be considered to be confirmed unless there is shoulder pain, and the test is therefore not satisfactorily performed under anesthesia. Rubin has stressed the diagnostic importance of kymographic tracings during insufflation.^{44,45} He believes that the oscillations recorded during insufflation represent tubal peristalsis and are useful in differentiating the varieties of tubal pathology. Stabile, however, has presented evidence that these oscillations are not of tubal but of myometrial origin.⁴⁶

Anatomical tubal abnormalities are perhaps more accurately assessed by hysterosalpingography. This

procedure is indicated when insufflation has not unequivocally established the presence of tubal patency, or if pregnancy has not ensued after a reasonable period of observation, even when insufflation has been satisfactory. Radiopaque material is introduced into the uterine cavity and tubes through a cannula similar to that used for insufflation, and films are taken at appropriate intervals. The use of fluoroscopy during the procedure has been recommended.^{47,48} When oil-based material is used, its peritoneal distribution can be ascertained roentgenologically after 24 hours. Normally the dye is evenly distributed, and when it is confined to localized areas, pelvic adhesions should be suspected. The amount of radiopaque material required to outline the Fallopian tubes and find extraperitoneal egress seldom exceeds 4 cc.⁴⁹ Foreign body reactions to oily media do occur, and restriction of the quantity used reduces their incidence. At that, when dye is retained in the tube because of closure, lipoid granulomata occasionally occur.^{50,51} Intravasation of media has been described, and oil embolism is a theoretical possibility.^{51,52} For these reasons opposition to the use of oil-based media has been voiced, and water soluble media advocated.^{53,54} The individual physician must weigh any disadvantages against the known diagnostic advantage of delayed follow-up film.

The opinion has often been expressed that both insufflation and hysterosalpingography have not only diagnostic but therapeutic value in infertility.^{47,54,55,56} Sharman has obtained pregnancies following pelvic examination and simple introduction of a uterine sound in 17 per cent of his patients,⁵⁷ and claims for the therapeutic effectiveness of any procedure in infertility must be evaluated with this in mind. In their statistical studies, Buxton and Southam have been unable to ascribe a therapeutic role to either procedure.⁵⁸

Culdoscopy is now of proven usefulness in the evaluation of the anatomical status of the pelvis. With the patient in the knee-chest position, the Decker culdescope can be introduced into the pelvic area through the posterior cul-de-sac, allowing adequate visualization of the tubes, ovaries and surrounding peritoneum.⁵⁹ Asymptomatic adhesions, often undetected by insufflation or hysterosalpingogram, are diagnosable by this method, and the etiology of previously inexplicable infertility is uncovered.^{60,61,62} Kelly and Rock report unsuspected pelvic pathology in 84 of 417 successfully per-

formed culdoscopies, permitting an intelligent discussion for or against laparotomy for sterility.⁶³ The procedure is contra-indicated when the uterus is in fixed retroversion. This condition, when associated with long standing infertility, is, of itself, justification for exploratory laparotomy, provided other causes for the infertility have been ruled out. Here, reproduction failure is attributable to associated pathology which causes the retroversion to be fixed, and not to the actual position of the uterus.

Treatment of anatomical derangements of the tubes is surgical. Patients with peritubal adhesions and patent tubes offer the best prognosis. When there is tubal occlusion at the fimbria, Mulligan and Rock have recommended that a polyethylene hood be placed over the reconstructed ostium to prevent reformation of adhesions about the fimbria during healing.^{64,65} The hood is removed at a second laparotomy in six to eight weeks. When there is cornual occlusion, patency after tubal reimplantation may be maintained with a splint of polyethylene tubing. This is passed through the uterus, sutured in place at the cervix, and allowed to remain in situ for at least six weeks. Results with these newer methods of tuboplasty, though far from satisfactory, have been encouraging. Tuboplasty should not be performed except after all other causes of infertility have been eliminated and the diagnosis of tubal closure is definitely established. Tuboplasties are delicate surgical maneuvers and require fine dissecting instruments, probes and other specialized equipment. Ideally they should not be performed except by those thoroughly trained in the specialized techniques involved.

OVARIAN FACTORS

Evaluation of the functional status of the ovaries is of obvious clinical importance. The presently available methods for the diagnosis of ovulation are indirect and depend on the detection of hormonal changes. When the menstrual periods come at regular intervals and are of about equal duration they are usually ovulatory.^{66,67} In the absence of pregnancy, ovulation is normally followed by menstruation in 12 to 16 days.⁶⁸ Mittelschmerz or frank vaginal bleeding may sometimes accompany ovulation. Blood has been detected microscopically in the cervical mucus at ovulation time in 60 per cent of women studied,⁶⁹ and the benzidine test is positive for occult blood in 90 per cent.⁷⁰

The basal temperature chart is one of the most

practical of the methods of ovulation detection. The patient is instructed to record her waking oral temperature daily. Typically, within 48 hours of ovulation, there is a thermal drop in the graph followed by a sustained rise, brought about by the thermogenic effect of progesterone.^{71,72} The temperature usually drops again with menstruation. If pregnancy has been established, the postovulatory temperature level is maintained, presumably by continued activity of the corpus luteum.^{73,74} The time of ovulation in a given cycle cannot be determined from the temperature chart until there has been a sustained postovulatory rise, and efforts on the part of the couple to regulate coitus by observing daily temperature fluctuations frequently result in tension and frustration. Progesterone production resulting from the ovulatory process causes modifications in endometrial morphology which are progressive and predictable.^{75,76} These are conveniently assessed by endometrial biopsy, a simple office procedure. In the dating of ovulation there is a good correlation between endometrial morphology and the temperature chart.⁷⁷ Like the temperature chart, biopsy is useful in this regard only after ovulation has occurred.

Vaginal smears are useful in ovulation detection. For adequate evaluation, smears taken on successive days in the pre- and postovulatory phases are required. The staining method of Shorr is the most satisfactory.^{78,79} Their interpretation is based mainly on the amount of cornification of the cells, which is greatest preovulatorily at the time of the peak estrogen level.^{80,81} Other criteria are also useful.⁸²

Farris has suggested a test for ovulation based on the changes in rat ovaries brought about by a gonadotrophin in the urine of women in the preovulatory phase.^{83,84,85} Urine is collected daily and administered to the rat subcutaneously. Four days preceding ovulation, ovarian hyperemia is said to be produced, and ovulation is thought to coincide with the last day of this reaction. The accuracy of this test has been challenged,⁸⁶ and it is of questionable value to the average clinician.

The causes of ovulatory failure are multiple. The difficulty may originate in the ovary itself, the hypothalamus, the pituitary gland, or from the influence of the adrenal and thyroid glands on the reproductive tract. A carefully planned diagnostic program is essential for proper management.

The influence of the psyche on ovulation has been well documented.^{87,88,89} This is probably mediated,

neurally or hormonally, through the hypothalamus. Cases of "hypothalamic amenorrhea" are not uncommon. The diagnosis is made by exclusion. Normal menstrual behavior is frequently re-established spontaneously after simple reassurance, but when there are deep-seated psychological disturbances, psychotherapy is required.

Pituitary involvement is rare among infertility patients. Hypopituitarism occurs as a result of acute necrosis secondary to severe obstetrical hemorrhage,⁹⁰ or from destruction by tumor. The extreme picture is that of pluriglandular deficiencies. Gonadal failure usually occurs early, and amenorrhea may be the first presenting symptom. Estrogen production is diminished. Urinary F.S.H. levels are low to absent, differentiating these cases from those with primary ovarian failure.

Patients with primary ovarian failure are conveniently divided into two categories: those in which estrogen production is maintained but ovulation has ceased, and those in which both estrogen and ovulation are absent. The latter group includes the rare cases of "premature menopause" and those with ovarian agenesis. They exhibit evidence of estrogen deficiency in that the endometrial biopsy reveals an inactive endometrium, repeated vaginal smears show absence of estrogen effect, and withdrawal bleeding does not follow the administration of progesterone. Urinary F.S.H. levels are elevated, the pituitary gland having been relieved of the inhibiting effect of estrogen. There is no known treatment for the infertility in such cases, though menstrual periods may sometimes be induced by the cyclic administration of estrogen alone or estrogen and progesterone.

Patients with ovulatory failure with continued estrogen production may exhibit amenorrhea or "dysfunctional flow," with periods unequal in frequency and duration. Cyclic progesterone therapy is helpful in regulating their menstrual pattern. Holmstrom has reported the re-establishment of ovulation during periodic treatment with 25-50 mg. of intramuscular progesterone.⁹¹ Swartz and Jones have been unable to confirm this in a small number of cases.⁹² Buxton and Southam report that the pregnancy rate among patients with "ovarian dysfunction" did not differ appreciably between the cases treated hormonally by various methods and those which were not.⁹³

Low dosage ovarian radiation, with or without accompanying pituitary irradiation, has been ad-

vocated for cases of "ovarian dysfunction" and infertility. The impression gathered from the literature is that the majority of reported cases show ovulatory failure with continued estrogen secretion. The total dosage of irradiation recommended has ranged between 100r.^{94,95} and 225r.,^{96,97} delivered to the ovaries in three or four weekly treatments. The therapeutic value of pituitary irradiation has been questioned.⁹⁶ Ovarian irradiation is definitely to be avoided in patients over 35 years of age,^{95,98} in those with but one ovary, and when the possibility of an early pregnancy has not been excluded.⁹⁴ Israel has reported 24 pregnancies among 90 amenorrheic women treated with irradiation,⁹⁴ and similar results have been reported by others.^{99,100} Many geneticists have objected to this form of therapy because of the possibility of producing mutations.^{101,102} Rubin¹⁰³ and Kaplan¹⁰⁴ have reported normal offspring in the third generation following irradiation. Russel,¹⁰⁵ Warren and Hicks,¹⁰⁶ and Newell¹⁰⁷ point out, however, that the material presented by them is inadequate for drawing general conclusions about genetic hazards and that recessive mutations may have passed unnoticed. No physician should recommend "therapeutic" ovarian irradiation until he has considered its genetic implications, well and briefly described by Rugh.¹⁰² Certainly ovarian irradiation should not be administered until diagnostic measures have failed to uncover a condition which is amenable to other forms of therapy.

The association of polycystic ovaries and ovulatory failure was first pointed out by Stein and Leventhal in 1935.¹⁰⁸ They described a syndrome of hirsutism, obesity and infertility with ovaries characteristically having a thickened capsule and multiple cystic follicles beneath it. The diagnosis can be confirmed by culdoscopic examination, the typical appearance of the ovaries being unmistakable. The treatment is bilateral ovarian wedge resection, and when cases are properly selected, the prognosis is excellent. Stein has reported restoration of menstrual function in 95 per cent of his cases so treated, and pregnancy in 88.7 per cent.¹⁰⁹ The etiology of this condition remains obscure. Recently attention has been given to the interrelationship between polycystic ovaries and adrenal cortical function.^{110,111,112} Suppression of adrenal activity with cortisone in those cases of polycystic ovaries showing, in addition, adrenal hyperactivity, indicated by elevated 17 ketosteroid excretion, has yielded promising results.^{111,112}

There is little doubt that adrenal activity does influence gonadal function. Patients with congenital adrenal hyperplasia present the clinical picture of female pseudohermaphroditism with amenorrhea. Suppression of adrenal activity with cortisone results in feminization, and, in those cases in the reproductive age group, ovulatory menstrual periods.^{113,114} When adrenal hyperplasia begins later in life, the clinical picture includes amenorrhea, clitoral hypertrophy, hair growth on the face, limbs, and trunk, acneiform facies, and obesity, associated with elevated urinary 17 ketosteroid excretion. Here too, treatment with cortisone frequently results in the institution of ovulation and pregnancy becomes possible.^{111,115,116}

Cases have been reported in which cortisone was thought to have been effective in establishing ovulation in the absence of laboratory evidence of adrenal hyperactivity.^{115,117} Cortisone has even been advocated empirically in cases with ovulatory cycles and inexplicable infertility,¹¹⁸ though no scientific rationale for its use has been advanced. Its effectiveness is by no means established and evaluation must await further clinical trial. Cortisone is not a harmless drug, and whenever it is used, its contra-indications should be carefully observed.

The inter-relationship between thyroid activity and gonadal function is not well understood. It is generally agreed that extreme degrees of deviation in thyroid activity affect gonadal, and therefore menstrual, behavior, and that appropriate therapy often results in return to normal ovarian function.^{119,120,121} Subclinical aberrations are sometimes demonstrable by laboratory studies in patients with ovulatory failure. Blood iodine determinations have been proven to be more dependable than the B.M.R. in the evaluation of thyroid function.¹²² When confined to those cases with laboratory evidence of thyroid deficiency, treatment is frequently effective in re-instituting ovulation. The use of thyroid medication empirically in euthyroid patients has repeatedly been shown to be worthless.^{15,123,124}

The occasional infertility patient shows evidence of ovulation with a luteal phase that is atypical. The postovulatory temperature rise is less than twelve days in duration, and there is a poorly developed secretory endometrium at menstruation.¹²⁵ This "atypical secretory phase" has been ascribed to premature senescence of the corpus luteum.¹²⁶ Its exact relationship to fertility has not been established, and such patients are known to be capable of conception

without therapy. Progesterone in the postovulatory phase,¹²⁷ small daily amounts of estrogen,¹²⁸ and chorionic gonadotrophin¹²⁹ have been recommended. The efficacy of any of these has not been established.

EMOTIONAL FACTORS IN INFERTILITY

The statistical studies of Buxton and Southam indicate that a significant percentage of infertility patients conceive after nothing more than a preliminary office visit.⁵⁸ Some are pregnant even before seeing the physician. It is tempting to conjecture that the release of emotional tension associated with the decision to seek help may have played a role. A couple's emotional status certainly may influence the frequency of coitus and so affect fertility. There is frequent allusion in the literature to tubal spasm as a mediator of psychosomatic infertility. Spasm is often noted during uterotubal insufflation or hysterosalpingography, but there is no evidence that spasm can be sustained long enough to account for infertility. There is need for more active co-operation between psychiatrists and reproductive physiologists in this vital area.

A list of references will be published with reprints.

Agreement Reached on Iowa Decision

In the now famous court decision in the State of Iowa involving the corporate practice of medicine a decision was rendered in favor of the medical profession and against the Iowa hospitals. The Iowa Hospital Association then appealed the case.

This appeal is now at a standstill because the physicians and hospitals in Iowa resolved the situation by agreement on November 8, 1956. Both the Iowa State Medical Association and the Iowa Hospital Association have ratified an agreement whose highlights are as follows:

1. There cannot be an employer-employee relationship between a hospital and a physician.
2. Radiology and pathology services are medical services.
3. Bills for radiology and pathology services must be submitted in the physician's name.
4. Radiology and pathology services that have been paid for by Blue Cross in the past will now be paid for by Blue Shield.

5. Hospitals may own and maintain laboratory and x-ray facilities and may operate them within the purview of the Joint Declaration.

6. Hospitals are to employ technologists and technicians unless it is mutually agreed otherwise.

7. The employment, discharge, and disciplining of technologists and technicians and the establishment of fees are to be accomplished by mutual agreement between the doctor and the hospital with the Joint Conference Committee of the hospital resolving any differences.

8. Hospitals are not to interfere with professional medical acts of the doctor or technologists and technicians under his supervision.

9. A contract may be oral or written and shall provide for compensation as agreed to by the parties involved, but any compensation arrangement must conform to the principles contained in the Joint Declaration.

10. By unanimous agreement of the six conferees, the Joint Declaration is limited to resolving problems of radiology and pathology. This grew out of the belief that if agreement could be reached in these specific areas, it would make it easier to resolve other problems that may exist.

11. Local settlement between doctors and hospitals is stipulated in the agreement.

In substance the agreement gives physicians virtually everything they wanted and contended when the original suit was conducted in the Iowa district court before Justice C. Edwin Moore.

It is understood that both parties to the agreement have now joined forces to appear before the State Legislature in Iowa in January to ask for changes in the laws which would spell out the agreement, and give it legal sanction.

Both the Iowa Hospital Association and the Iowa Medical Association are to be congratulated for this wise and, it is to be hoped, final move.

7,686 Students Enter Medical Schools

A recent report by the American Medical Association shows that 7,686 students, a record number, entered medical schools in the 1955-56 academic year. Of this number, 5,753, or 75 per cent, had four years of college education.

THE PRESIDENT'S PAGE

THE National Academy of Sciences and the National Research Council issued a report in June, 1956 on the harmful effects of radiation to the human body, particularly to the gonads. This report has been followed by many rather unscientific articles which have stressed the hazards of radiation so that potential dangers have been magnified out of proportion to the real value of x-rays and other ionizing radiation in the diagnosis and treatment of human ailments.

It is common sense to make every effort and to use every device to keep radiation in medical management to a minimum and to protect areas of the body not under investigation from unnecessary exposure. It is also common sense to restrict to a minimum the unlimited and unnecessary use of diagnostic x-rays in routine investigations of well people. It would not, however, make sense to restrict the use of x-rays and radioactive substances in the diagnosis and treatment of the sick because to do so would lead to delayed diagnosis, poor diagnosis, and to ineffective treatment.

The maximum permissible accumulated radiation to the gonads given by the National Academy of Sciences of ten roentgens of man-made-radiation from conception until the age of thirty is an arbitrary figure and not necessarily factual. Nevertheless, every effort should be made by radiologists to keep radiation to the reproductive organs of any one person below the maximum level. It has been estimated that the reproductive cells of most people who have diagnostic x-ray examinations over this period of time seldom receive anywhere near the maximum amount. The average is between three and four roentgens.

Radiologists and others in medical and allied fields who have been indoctrinated in the biological and physiological aspects of x-rays and radioactive substances are aware of the danger from injudicious or excessive use of these agents and of their effect on the reproductive organs. These specially trained people are familiar with and make use of ways and means of reducing undesired radiation to a minimum. It is natural for them to use every means to protect the patients themselves and their co-workers from unnecessary exposure. The public should be assured that x-rays and radioactive substances are safe in the hands of radiologists and those who know how to use and control them. It also should realize that they are not as safe in the hands of the unskilled and careless.

Ralph T. Ogden, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

CALL

ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1957 Annual Meeting of the House of Delegates will be held in the auditorium of the East Hartford High School, East Hartford, commencing at 10:00 o'clock in the morning of Tuesday, April 30.

Following luncheon, the House will reconvene for the completion of business.

Ralph T. Ogden, President
Creighton Barker, Secretary

INTRODUCTION OF RESOLUTIONS

Article VII, Section 4 of the By-Laws of the Society provides:

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual, or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual, or special meeting by the Council and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of paragraphs 1 and 2 of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

COUNCIL MEETING

The monthly meeting of the Council was held on Thursday, February 28, 1957.

The meeting was called to order by the Chairman, Dr. Fincke, at 4:30 P. M. There were present in addition to the Chairman Dr. Fincke, Drs. Ogden, Walker, Couch, Barker, Weld, Danaher, Feeney, Gallivan, Archambault, Gens, Meyers, Buckley,

Dwyer, Gilman. Absent were Drs. Murdock, Gibson, Stringfield, Ursone, Tracy, Otis, Kristan, Ottenheimer, Clarke, Starr.

This meeting followed immediately after a meeting of the sub-committee on the Report of the Hospital Committee, Dr. Weld, chairman.

The copy for the referendum on compulsory

social security coverage for physicians was presented by the executive secretary and approved as presented with the notation that the words "Must Be Signed," to appear on the ballot should be very conspicuously printed. The other details of the referendum procedure proposed by the secretary were also approved.

The recommendation concerning a community program for polio vaccination submitted by the Committee on Public Health was agreed to and approved with the proviso that the phraseology of the recommendation be revised and improved before it is published in the JOURNAL.

A communication from Mr. Alan W. Chadwick, acting manager of the Veterans' Administration Hospital, West Haven, relating to a polio vaccination program for employees at that hospital was presented. The Council voted unanimously to approve the project as outlined by Mr. Chadwick.

The community program for mentally retarded children suggested by a group of Connecticut health agencies and approved by the Society's Committee on Public Health on January 10, 1957 was discussed briefly and approved.

Dr. Weld reported on the actions taken at the meeting of the Sub-Committee to Study the Report of the Committee on Hospitals which had been held immediately preceding this Council and recommended that a motion be presented to the House of Delegates on April 30 to rescind a previous action of the House of Delegates (April 26, 1955) and to replace it with a more clearly cut directive as to how the Committee on Hospitals should proceed. Dr. Archambault and Dr. Gilman agreed to collaborate with Dr. Weld in the preparation of this motion and new directive. It was also recommended that arrangements be made for a conference with representatives of the Connecticut Hospital Association for the purpose of discussing the employment of physicians by hospitals. It was agreed that Dr. Gallivan would collaborate with Dr. Weld in preparing an outline for such a conference. Both of these recommendations were approved unanimously.

An invitation was presented for the Society to become a member of the New Haven Taxpayers Research Council. It was voted not to accept this invitation.

A letter was presented from Dr. William H. Keeler, director of Medical and Health Services,

Office of Civil Defense, State of Connecticut, asking that the Council "take whatever steps it may feel it can," to further the approval of the next biennial civil defense health services budget, \$2,517,934. \$50,000 has been requested and no sum approved by the Budget Committee and the Governor. It was voted to take no action upon this request.

A letter was presented from Dr. William H. Keeler, director of Medical and Health Services, Office of Civil Defense, State of Connecticut, relating the designation of physicians to attend a course on the "Management of Mass Casualties" at the Walter Reed Institution for Medical Research, Washington, D. C. Although this matter has been before the Council before, the details of the project are not clear and no information is available as to the three physicians who had been chosen by the Society's Committee on Emergency Medical Service. The secretary was directed to communicate with Dr. Benjamin B. Whitcomb, Hartford, chairman of the Committee on Emergency Medical Service in an effort to clarify the details.

Dr. Archambault, chairman of the Professional Policy Committee of Connecticut Medical Service presented a letter from the executive director of CMS reporting four cases in which physicians had operated upon members of their immediate family and filed claims for reimbursement from CMS. The subject was widely discussed and it was finally voted that: "The Council considers it highly improper for a physician to seek to collect payment from Connecticut Medical Service for services rendered to members of his own family." There was one dissenting vote.

Neil Murdo MacLean, Byram, Connecticut. A.B. Hamilton College, June 1956. College of Physicians and Surgeons, Columbia University, class of 1960, was elected as a student member of the Society. Father: Kenneth MacLean.

A report of the Committee on State Legislation, prepared by the Chairman, Dr. Burgdorf, was presented. This was discussed at length. A meeting of the committee was held on February 20 for the purpose of reviewing certain bills relating to health and welfare now pending before the Connecticut General Assembly. Specific recommendations relating to particular bills were also included in the report and these recommendations were approved by the Council.

Dr. Feeney, chairman of the Conference Committee with the Connecticut State Bar Association outlined a proposed medical-legal conference to be held in Hartford, for the physicians and attorneys in Hartford County on May 6. It was also stated that this would be the beginning of similar conferences that would be held in other counties of the State. It was voted to approve the project as outlined by Dr. Feeney and to appropriate \$250 to defray the expenses of the conference.

The meeting adjourned at 7:00 P. M.

Meetings Held in March

- March 1—Connecticut TV Committee for Health Education
- March 5—Women's Auxiliary, Public Relations Committee
- March 11—Committee on Eye Care
- March 12—Connecticut Medical Examining Board
- March 13—Connecticut Medical Examining Board
Accident Prevention Committee
School Health Committee
Committee on Hospitals
Perinatal Morbidity and Mortality Committee
Committee on Industrial Health
- March 14—Connecticut Medical Examining Board
Committee on Public Health
- March 19—Executive Committee of Health League
- March 21—Committee on Emergency Medical Service
- March 25—Connecticut Tuberculosis Association
- March 27—Committee on Maternal Mortality and Morbidity

All Purpose Cards to Be Used for Medicare

Defense Department has decided to issue an "all purpose" identification card for dependents, one that will be used for medical care as well as for establishing commissary and other rights and privileges. In the Dependent Medical Care Program it will replace the current "Dependency Authorization for Medical Care Card," but will keep the same designation, DD1173. The Army, handling Medicare for all services, expects to have the cards in use by July 1. Public Health Service dependents will use the same card as the military. In officially announcing the change in the Federal Register,

Defense Department said uniformed sponsors will be responsible for informing authorities of any change in status of dependents.

POLIO VACCINATION PROGRAM

Recommended by Committee on Public Health and Approved by the Council

An effective immunizing agent has been developed and demonstrated to be of great value in preventing paralytic poliomyelitis when it appears in generalized endemic and localized epidemic form. When the material first became available and in short supply there was an eagerness on the part of the people, stimulated by various promotional programs to receive it, to protect themselves against the disease.

During the past two or three months the emotional urge has declined and there are large numbers of people of all ages yet to be immunized. There is now an abundant supply of the vaccine and new efforts must be put forward to encourage the public to protect itself.

Therefore the State Medical Society urges all of its constituent members to promote the immunization every day in their private practice regardless of the ordinary limitation of the specialties, and furthermore urges them to participate actively in every ethical program that may be developed in their respective communities so that every person may have an opportunity to be immunized before the 1957 polio season.

Two New AMA Exhibits to Bow at June Meeting

Two new AMA scientific exhibits designed primarily for physicians will be unveiled at the Annual Meeting in June in New York City, "Health Appraisal of the School Child" and "Foods in Oral Electrolyte Therapy."

These displays are being prepared jointly by the Bureau of Exhibits and (1) the Bureau of Health Education and (2) the Council on Foods and Nutrition. Both will be available on a loan basis to medical societies after the Annual Meeting.

FROM OUR EXCHANGES

Rundles of Duke University reported at the Third National Cancer Conference held in Detroit in 1956 (*C.A.*, 6:5, September 1956) that "reasonably rapid progress" is being made toward the eventual control of multiple myeloma. In a series of 124 cases studied over eight years, one third were not helped because of delayed diagnosis and treatment, one third received moderate benefit, and one third received great help from cortical steroids and urethane. He believes that the Chester Beatty compound 1248 shows promise.

* * * *

Randall in a guest editorial appearing in the *Pennsylvania Medical Journal* (59:7, pp. 523-524) discusses a subject titled "The Sociologic Features of an Older American Population." The number of older people (using 65 years as the dividing line) increases daily at the rate of about 1,000. This increase affects every phase of American life.

The effect is first felt by the individual who suddenly finds himself among those who are wanted and used less and less by those around him. His problems when compounded by those around him who are likewise "old" inevitably become the problems of the community.

A feature of this change in the composition of the population is the effect on the family. Today there is scarcely a family in the country which is not concerned to some extent with the needs and care of one or more older persons. With the much increasing expansion of cities and towns, and the constant movement from place to place, the modern tendency is for each generation to be responsible for its own needs. If these cannot be met there is a tendency to turn to the community for whatever is needed, from counseling to financial aid.

The movement of young families to the suburb is leaving behind in the so-called "inner cities" many of the low income and under-privileged individuals who either cannot or do not wish to leave familiar surroundings. Many of these are older people, for the majority of whom incomes are apt

to be below \$2,000. Only in cities in which a large percentage of industry is located can the dwindling tax income from the "inner city" meet the increasing cost of government and these services it must render.

Many communities are faced with the question as to whether they can support in idleness, even on low and limited incomes, the growing number of older people now being retired at the "normal" retirement age of 65. There is a searching inquiry going on by industry and government for the purpose of developing sound criteria for retirement which, together with age, can be so applied that individuals who still have capacity and wish to do so may have the opportunity to work, for their own sake and for the sake of the economy of the community. These criteria cannot be established until further scientific advances have been made by the medical profession so that both physiologic and psychologic measurements can be objectively applied.

Healthwise there are advantages and disadvantages for older people, sociologically speaking. Many people live longer in fair health, so that they can be expected to be productive to an older age than they once could. Mortality rates among old people have improved so that 275,000 were living in 1950 who would have died in 1900. These survivors are more vulnerable to disease so that the resulting impact on the resources of the community has enormously increased. Families and communities are struggling with the hard fact that funds for adequate care are lacking; resources or facilities are in short supply, as are the professional personnel, if the care required to apply the knowledge and skills which are ours is to be applied.

Longer life is not yet the gift we would have it. However, since progress in understanding those things which have shortened life has come about in a half century, there is reason to believe that there will be progress in controlling to a greater extent those forces which now affect adversely the later years of life.



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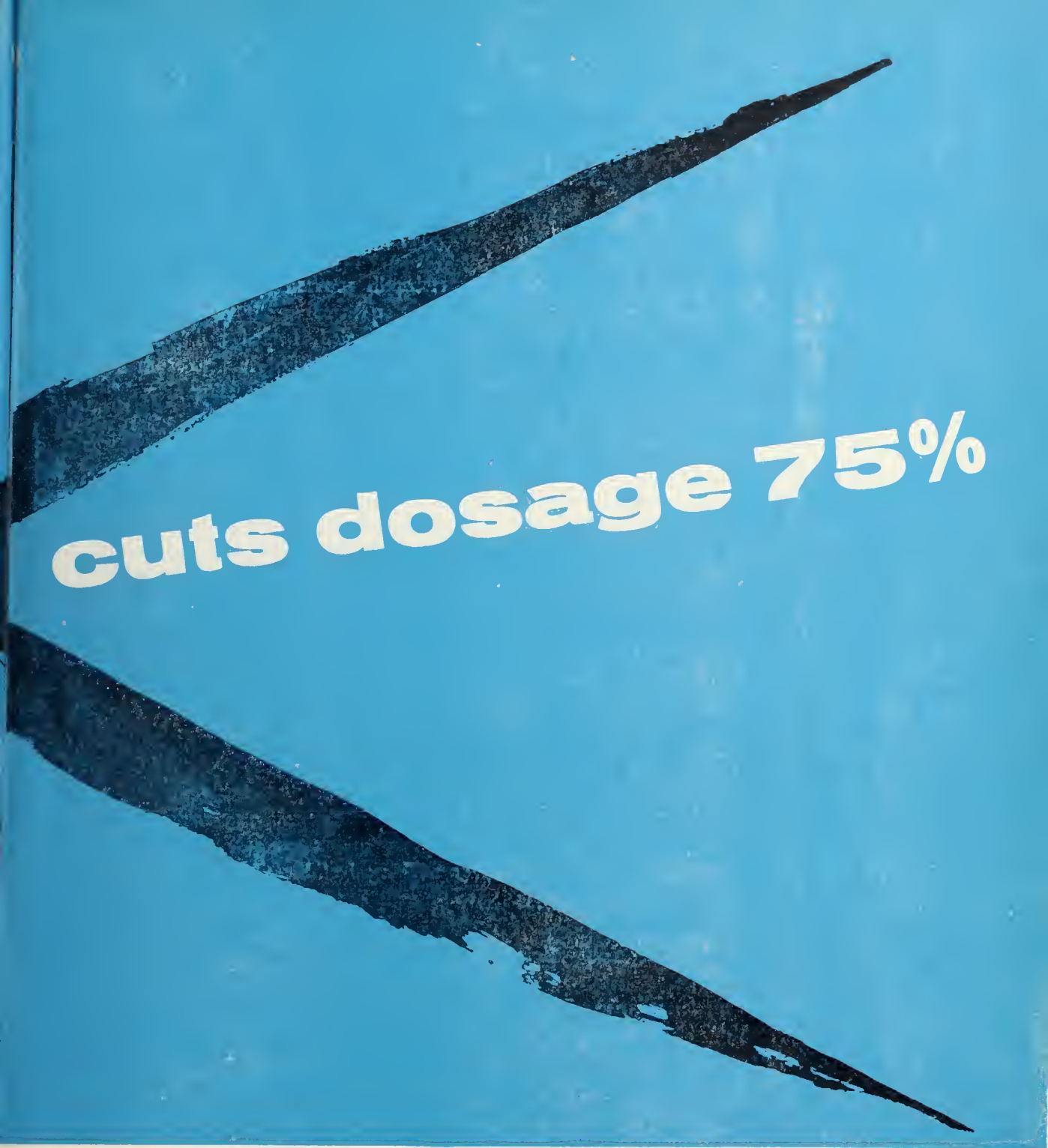
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THE HISTORIAN'S NOTE BOOK

FOUND! THE RECORD OF THE 1767 MEDICAL SOCIETY IN LITCHFIELD

BYRON STOOKEY, M.D., *Sharon*

A notice on December 21, 1767¹⁰ called the third meeting of the society for the third Tuesday of January, 1768, instead of the second Tuesday, since the County Court would be in session during the second week of the month, and the Court House consequently not available to the society. Likewise the meeting in January, 1769¹¹ was changed to the third Tuesday.

At this last meeting it was determined to present a memorial to the General Assembly, a committee was appointed to prepare the memorial, and on May 8, 1769¹² the following notice appeared:

At the last convention of the Medical Corporation in Litchfield County, a committee was appointed to prepare a memorial, to lay before the corporation, on the second Tuesday of June next to be presented to the Hon. General Assembly at their sessions in October next (if agreed to by the corporation). The members are hereby desired to take notice and give their attendance.

Samuel Catlin Clerk

Litchfield 1st May 1769

With this announcement of the corporation's intention to vest in itself the power of examination, and practical control of the right to practice medicine and surgery, opposition appeared. That opposition was carried on in the *Connecticut Courant* during the summer and fall of 1769 in articles that were unfortunately anonymous. As will be seen, the remarks became rather bitter and acrimonious. The intemperate public discussion could not have been conducive to favorable action on the part of the General Assembly.

The following appeared June 19, 1769:¹³

Union is the band of society, and (in many cases) of the utmost importance, The necessary Cement of incorporate bodies, and many other connections in

life - - - And (where confederacies are not dangerous, and destructive of civil liberty, or property) is a duty which ought always to be inculcated.

There are some corporations that are of very great utility to mankind - - - others, that seem to wear such an aspect, but upon critical examination, appear to be of a contrary tendency, - - - Our own understanding and experience, must point out the advantages, and disadvantages of such connections. And when any society, or body incorporate, is found not to answer the general good, as was propos'd in its formation, it is best in such case, to disband. Such (I humbly conceive) the medical corporation of Litchfield county to be, - - - The design of this society was to promote a good agreement, and harmony amongst it's members, endeavour to be mutually assisting to each other, in the healing art, and to keep out all Quacks, and vain pretenders to Physic. But if experience (the best guide, in all human affairs) sufficiently teaches us, that these ends cannot be answered, then the very design of its institution is frustrated, and at an end. I shall here offer a few reasons why I think these cannot be answered, under the present constitution of said society. - - - And here first. The grand thing, which is to keep out Quacks, and pretenders can (under it's present constitution) in no measure be answered. We have had too many proofs of this (since the formation of the society) to doubt of the truth of the assertion. - - - An instance of late of the society's receiving one into their body, who had read some, but never liv'd with any practitioner, or been in the practice himself - - - but he now comes, cloath'd with the authority of the society, recommended to the people, as one worthy to be apply'd to in case of life and death. - - - And yet I sincerely think that the person, they have thus recommended, would pass a better examination than one half of the examiners. And if this is the case, there is no possibility of keeping out Quacks. Every member of the society has an equal right to vote, and if the major part are pretenders, themselves, then how will the formation of such a society keep

(Continued from March issue)

out pretenders? And tho' the person refer'd to above, may make a good practitioner in time, yet I think he is by no means qualified at present, and life is too dear to be trifled with in this manner. I know the excuse of some of the principal members of the society is, that they were impos'd upon - - - but if Quacks, and pretenders, can impose upon the society then how is the society constituted to keep out Quacks and pretenders? The more united then a corporate body are, (the major part of whom are unqualified persons themselves) renders it (in proportion) hurtful to mankind. A society whose very formation and existence recommends a number of unqualified persons to the public, where the lives of mankind are concerned, is hurtful in its very nature; and the sooner disbanded the better. - - - Besides I am not certain but that a confederacy of Doctors might be hurtful to society (even on supposition they were never so well qualified) the matter of medicine lies much in the dark, (with regard to the vulgar) and it is very difficult for common people to determine whether they are well or ill used in demands made upon them, and a combination of Doctors perhaps gives them a greater advantage to impose on mankind by extravagant demands, than if no such combination had been form'd.

Moreover there are some obligations to the laws of the society, which I think are not in the best manner calculated to answer the good ends propos'd - - - one I would in a special manner remark upon, which is that no fellowship, or council is to be held, with such as are not of their communion (tho' never so well qualified in other respects) if any regular practitioner in the county should upon the whole, think it not best to join with the corporation, &c. he must be discountenanced, and all the injury possible done him, so far as the influence of the corporation can extend, but another that has no other qualification to recommend him, but only that he has join'd the medical club, must be crest, and recommended to mankind as an able physician, when he scarcely knows the difference between a Bagpipe, and a Glysterpipe - - - Where is then the justice or equity of this method of proceeding? Or how is it consistent with principles of liberty? Union (on a good basis) is desirable, on a bad one worse than nothing, and notwithstanding all the pretensions to friendship so warmly asserted; I wish there was no reason to complain of insincerity even among some of the principal members, and first promoters of the affair, some who are desirous to glorandize themselves and father their blunders upon their neighbours, some men have a peculiar faculty *but* come by innuendo's to exculpate themselves (in their horrid mistakes) and make others bare the blame.

I have had the honour to be a member of the society myself, but (from what little experience I have had) I am fully convinc'd, that the foundation is deficient; and in consequence the superstructure can't be good.

In reply July 31¹⁴ and August 7, 1769¹⁵, the following:

In your paper, No. 235, I find a very extraordinary piece - - - the ingenious author of this admirable performance, after sundry learned positions concerning union, incorporate bodies, confederacies, &c., hath bro't in a heavy charge against the medical corporation of Litchfield county. I was not a little surpris'd to find a person so destitute of understanding and lost to all virtue and goodness, as to write against any attempts for the regulation of the practice of physic; when its well known that all learned and wise nations have thought it not only their interest, but indispensable duty to encourage physical societies - - - I shall not waste time and paper, in taking notice of the ungenerous and unpolite reflections with which this writer hath loaded the medical corporation; but only remark upon the inconsistency and incoherence of his satyirical harangues. He says, "when any society or body corporate is found not to answer the general good as was propos'd in its formation, it is best in such case to disband." "Such (says he) I humbly conceive the medical corporation of Litchfield county to be." What this general good is, that was propos'd in the societies first formation, our author tells us, where he says the design of this society was, "to promote a good agreement amongst its members, endeavour to be mutually assisting to each other in the healing art, and to keep out all quacks and vain pretenders to physic." But this grand thing says he which is to keep out quacks and vain pretenders, "can, under its present constitution, in no measure be answered." We have had, continues he, "too many proofs of this (since the society's formation) to doubt of the truth of the assertion." What these proofs are, which our author hints at, I am unable to guess, unless it be true (as he says in his close) that "he has himself had the honor to be a member of the society." The first argument brought to prove this daring assertion is, that the society have lately received one into their body, who had read some, but never liv'd with any practitioner or been in the practice himself. To which I answer that had the society receiv'd such a one into their body, it would be no argument against its honor or rectitude, for this very person, with a good genius, and the help of books, might be a good theorist, and well qualified for the practice, without ever living with any practitioner. Of this instances are notorious: witness some of the best physicians

in this colony, who were never under the care of any particular tutor. But here I must inform our author, that he has made a mistake; for I have attended every convention of the medical corporation for this two years last past, and no person has been received but who had been (more or less) under the tuition of some practitioner; nor have any been received, without examination, but such as have been some time in the practice; and for the truth of this I appeal to the corporation - - - I find that this uncommon writer differs very much in his sentiments from the rest of mankind. Let us now examine a little to see whether he agrees with himself. He says, that "the design of the society was to promote a good agreement & harmony amongst its members, by assisting each other in the healing art, endeavouring to keep out quacks and vain pretenders." He also says that "the majority of this society are themselves quacks and vain pretenders." Now this accurate reasoner can't be so mistaken in his logic, as to suppose that this majority of quacks and pretenders had a design to keep out quacks and pretenders unless he supposes they had a design against themselves: he therefore must suppose that it was some of the principal members (as he is pleased to call them) who had this noble end in view. - - - Well, let us hear what his charity is for these principal members. - - - "I wish (says he) there was no reason to complain of insincerity even among some of the principal members and first promoters of the affair. Some who are desirous to aggrandize themselves, and father their blunders upon their neighbours." Now, if our author believes that the design of the principal members of this society is to aggrandize themselves, and father their blunders upon their neighbours - - - and also believes the majority of this society are themselves quacks, then he does not believe (as he says) that the design of the society was to promote a good agreement amongst its members, endeavouring to assist each other in the healing art, and to keep out quacks, &c. If he should say that altho' the design of the society in its first formation was good and honorable, yet it has now lost its honor and virtue. I will notify him that he has precluded himself from such a pretended evasion because he has said that the very existence and first formation of the society is bad, and the design of some of the principal members and first promoters of it is dishonorable.

The next thing worthy of notice is, what our author says concerning physical societies in general. His words are these, viz. "besides I am not certain but that a confederacy of Doctors might be hurtful to society (even on supposition they were never so well qualified.) The matter of "medicine lies very much in the dark (with regard to the vulgar)

and its difficult for common people to determine whether they are well or ill used in demands made upon them; and a combination of Doctors perhaps gives them a greater advantage to impose on mankind, by extravagant demands, than if no such combination had been formed." Here he has opened his mouth so wide that he has shewn his heart, and notwithstanding he pretends to point his virulent javelins against the medical corporation of Litchfield county in particular, he hath plainly shewn that he is an enemy to physical societies in general; and I think we have reason to suspect that he is unfriendly to all learning order and regularity: for in every nation where learning, wisdom and goodness have flourished, there they have always encouraged combination of Doctors, who were countenanced and protected by the legislature. He says, "a combination of Doctors might be detrimental to society on account of exorbitant demands." To which I answer, that a combination of Doctors is the only proper method to regulate physical demands; for Doctors and they only, are suitable judges in this matter; and altho' pecuniary interest is a thing that never yet came under the consideration of the medical corporation of Litchfield county, yet I presume that there is not a person in this colony (unless it be this singular writer) but who would choose to pay the demands for physical business ascertained by the said corporation rather than to leave it to every ignorant and extravagant medicaster to set his own prices - - - our author says, "that there are some obligations to the laws of the society, which he thinks are not well calculated; one of which (he says) is, that no fellowship or council is to be held with such as are not of their communion. If any regular practitioner in the country shou'd, upon the whole think it not best to join with the corporation, he must be discountenanced, & all possible injury done him, &c. To this I reply, that as physical good was the great end of the institution of this society, it was thought best in order to facilitate its growth to make a resolve to this purpose, viz. "that if any physicians in Litchfield county (after proper notice given them) refused to join the corporation, they were to be treated with neglect, and not to be invited by members of the corporation, to consult in physical cases." And this resolve had its desired effect; for every reputable physician in that county, very soon join'd the society. Now this resolve is in no wise inconsistent with principles of liberty, but perfectly correspondent therewith: it only injoins members of the corporation to call in such persons to their assistance, as they think are able physicians; but should a member of the corporation be obliged to hold fellowship with every ignorant empyrick, it would be an infringement

upon liberty with a witness! Our author concludes, with a declaration that he "has himself had the honour to be a member of the society," which declaration, if true, is the only one of any force that he has made use of against its honor or rectitude. - - - And altho' it is very difficult, if not impossible to keep all bad members out of any society; and when such members have got in, it is not easy to expel them, yet as the medical society of Litchfield is compos'd of physicians and surgeons, and their design is to assist each other in the healing art, and in all operations that may tend to the good of the body, and if our authors last declaration is true, I hope they will mutually agree to assist each other in the expulsion, or amputation of such a useless and corrupt member.

On October 9, 1769:¹⁶

I observ'd in your papers No. 241 & 242, an answer to a piece sometime before, containing some remarks, on the medical Corporation of Litchfield county (as they stile themselves) and am very sorry that the gentleman (whoever he was) in his attempts to vindicate the corporation, should say nothing by way of answer to the objections there made, unless to deny a plain matter of fact, capable of being fully prov'd, by a number of witnesses - - - Doubtless what the author of that first piece (attempted) to prove was, viz. that the propos'd design of the medical corporation (which was to keep out quack's and pretenders to physick) under it's present constitution, could not be answered. He produced an instance of a person's being recommended by said society, who had never liv'd with any regular practitioner in the character of an apprentice; and was (in his opinion) no ways qualified for the practice of physick as yet. (which seems now very evidently to be the case, in as much as he has declined it since, from a consciousness (as he himself owns) of not being (as yet) sufficiently qualified. In which I think he acts like a man of conscience. - - - And yet notwithstanding all this, the vindicator of the corporation in that labour'd performance of his, roundly affirms, that no such instance can be produced in the county. In that piece the author produced one instance to prove his opinion of the corporation. - - - now I will produce another, and that is, the receiving one into their communion (and thereby recommending him to the world, as an able physician) who had been pronounc'd by a number of the principal members of the corporation, but a few weeks before a non compos mentis, that is in plain English a fool - - - that he was not then, nor ever could be fit for the practice of physick - - - Now if these two facts are true, does it not fully prove his assertion, which is (by Mr. Vindicator thought) so bold - - - and that they

are true I am fully able to demonstrate - - - this conduct of the corporation very much displeas'd some of the members who were not present, in so much that they had almost come to a determination, never to attend the meeting of the corporation more - - - neither am I alone in my sentiments, many of the members have spoke with freedom, and have given it as their opinion, that above one half of the members of the corporation are not fit for the practice of physick - - - And because the author of the first piece has endeavour'd to set these matters in a true light, (with a view, no doubt if any thing should be done to regulate the practice of physick) it might be done to answer some good purpose, for which he is accused, by this able logician, as an enemy to religion, learning, and all that is good. But if his appearing to be inimical to quacks and vain pretenders, and to a corporation, whose very existance recommends a number of such to the world, has incur'd such an heavy charge, together with a threat of amputation and the like: I would have the Vindicator know, that, (as for my part) I have not liv'd so long in the woods as to be fear'd at an Owl, altho' it is a frightful Bird.

The author of the first piece has said nothing against regulating the practice of physick. - - - He has said nothing to discourage the practitioners in physick from uniting (in a proper manner) to discourage and discountenance vain pretenders. - - - All that he has said only militates against a corporation, that has in fact, recommended, and still continue to recommend, a number of such to the world. And because he did not distinguish between the real and profess'd design of the corporation, he is charg'd with inconsistency: but if the vindicator wants to know my opinion of such matters, undoubtedly the profess'd design was the thing he intended. However if I myself was to judge of the real design of some of its members, I should think, that a desire of distinguishing themselves, by public oration's and dissertations on physick extracted from Boerhaave, (excepting now and then a blunder, where the author trusting to his own legs venture's without his crutch) were the governing motives. And as to the laws and rules of said society, notwithstanding all the accurate reasonings to the contrary, I am still of the same opinion with the author of the first piece; especially that which forbids to hold communion with any who don't belong to the society (however learn'd and ingenious in other respects) he affirm'd that such imposition was inconsistent with the natural rights and liberties of mankind. And I think all the Vindicator has said (by way of proof) amounts to no more than this, viz. that all the physicians of note soon join'd the corporation, as tho' truth, and righteousness were

to be determined by vote. But suppose a man of learning and ingenuity should refuse to join with the corporation, and should offer this as a reason, viz. that the greater part of the members were unqualified, and no ways suitable to be consulted or trusted to in case where life lay at stake, must such a person be treated with contempt and neglect, because he can't sacrifice the peace of his conscience, and his love to his fellow men? which he thinks he must do, if he joins with the corporation. - - - Now if this is not imposition, I don't know what imposition means - - - The censure of such a society - - - and even aniputation from it, would be about as terrible as the Pope's curse to a Protestant. In both of which I believe there would be more found than substance. In short; I see but two places, wherein the author of the first piece appears to me to be in the least inconsistent. One is where he calls that society, or combination, by the name of *corporation*, and the other is where he says he has himself had the *honor* to be a member of the society.

October 30, 1769:¹⁷

The love of fame hath long since esteem'd an universal passion; various are the methods taken by mankind in pursuit of this mighty bubble: so fond are some, and so eager in the chase, that they will leap from precipices, plunge into the abyss, or even rush on certain death, merely for the love of fame. - - - Doubtless this single consideration induces some men to commence authors, although they do it, at the risk of their interest, and the everlasting reproach of their names. I can't conceive what other motive should influence the late lowliv'd, scurrilous scribler, to crawl forth from deserv'd obscurity, by means of the press, to public view, in public scandal, in two dirty libels against the medical corporation of Litchfield county; did he think to gain universal applause for his disinterested benevolence to the public, in shewing them their danger, and the admiration of the world for his extraordinary abilities as a politician - - - as it seems he did when he enters into the consideration of the construction of societies, their uses, &c. he tells us that "union is the band of society." But I observ'd he never told us what was the band of union in any society. It would have been as good sense to have said society was the band of union, so that his ideas seem to be as confused as his narrations are false, and his conjectures groundless, and all are notorious (if not to the world) to many witnesses. He boasts indeed of being such a sturdy boor as not to be frightened with an owl, (though a frightful bird). If he hath a mind to make full trial of his courage by frightful appearances, I would advise him, to look in the glass, and if he isn't frightened then, I will acknowledge he is fool hardy. - - - I shall not

take so much notice of this wretched scribler as to give him a serious answer to every particular in these jargonical epistles; but cannot pass by a particular objection he makes use of; for which he is rather beholden to the vulgar than they to him; (viz.) "That a combination of Doctors might be hurtful to society, (tho' ever so well qualified) in agreeing to impose upon people with respect to their accounts, and to raise exorbitant demands." It seems this *Monkey's mate* did not esteem honour, or honesty, to be necessary or useful qualifications, for a physician. I heartily wish that this was the only instance by which he had discovered that to be his sentiment, but this objection, come it from whence it will, hath no foundation in reason or commonsense; but the reverse of this supposition is notoriously true. - - - Not many confidants to a secret is a receiv'd maxim in politics. And I challenge him, or any other man to produce a single instance where physicians, in a public body, have been guilty of the evil here surmised, on the contrary, look among private practitioners of the knavish empirical sort: and instances will not be wanting - - - This very *Adamite* (if men of credit are to be depended on) is a notable one, who by means of his nostrums and arcana, takes advantage to oppress the few patients he hath with intolerable demands. And by this method, and this only, the people of this country have been imposed upon, oppress'd and abus'd, by doctors. To prevent which I know of no other expedient than the method taken by this corporation. Some menial servants, swol'n with pride and self conceit, thinking themselves of too much importance, to content themselves in the humble station in which providence hath placed them, have recommended themselves to the notice of the world, by clamouring abroad, misrepresenting the economy, and good order, of the honorable families to which they belong, until they are noticed with a witness; having thereby drawn upon them the odium, and just contempt, not only of that particular family, but of all mankind. - - - It amounts to a proverb, that it is a bad bird that fouls his own nest. Such a part this buffoon hath acted, and such treatment doth he deserve, and I hope no one of said medical corporation, will take any further notice of him or his writings for the future, than they would of a dirty *dump-tin*, just to kick it out of their way.

November 27, 1769:¹⁸

An Appeal to the Public in this Colony

. . . . Now with regard to the Medical Corporation of Litchfield county, who have lodg'd their memorial in the assembly; most say it's a good thing but I don't think they will obtain. If this is not a

grievous restriction on the honourable General Assembly, I know not how to word one. But since it's so common among the members 'tis to be hoped they will bear it the more patiently from others. Nevertheless I would hope better things of that venerable body; firmly believing that when matters come under consideration they won't judge the life of man beneath their notice; and that they will act their judgments uprightly - - - And if they think in their consciences, it is best to incourage every lazy ignorant fellow, (that's wicked and low-lived enough to use all the faculties of their souls to the utmost of their power, to impose upon the public, and cheat them at once out of their lives and estates, in order to support themselves;) they will say so: & if they think it best to frown on all endeavours for the promotion of true medical knowledge, they will say so, and if they to do any thing when call'd upon, will it not be an implicit declaration thereof? I have undertaken to answer several objections and I find myself strongly prest with another that will be apt to arise on reading this piece viz. That it is saucy and savours too much the nature of reflection: which I know not how to answer better, than in the words of Ben Johnson: When it was urg'd upon him that his speech was no rhyme (tho' he had undertaken to make one) "no (says he) but there is a deal of truth in it." And if the members of the General Assembly are grown so delicate, that they can't receive truth in its natural simplicity and plainness, but must needs have it trim'd off in Circeronean dress before they can hear it; 'tis to be hop'd the people will change them till they get such as will. Many of the happy consequences of a well regulated practice might now be set in a convincing point of light: but lest I shall be too tedious, shall add no more.

In spite of the opposition the memorial was carefully prepared and placed before the corporation for study and after due consideration on December 25, 1769¹⁹ the following notice appeared:

Notice is hereby given to the members of the Medical Corporation of Litchfield County, desiring all and every member thereof, without fail, to attend the stated convention on the third Tuesday of January next, at said Litchfield, in order to consult further what measures to take in support of the memorial of said corporation, now lying in the General Assembly, it having as yet had no public reading in the House, for some peculiar reasons, but has been privately read by most of the members thereof, who generally speak favourably of the same. Said memorial is laid over to the next session, and 'tis hoped will then meet with the approbation of the legislative authority.

Joseph Perry

Woodbury December 16, 1769

Though this memorial was before the October and May General Assembly I have been unable to find any reference to it in going over the transactions of the Assembly, presumably no public reading or action had been taken. However the following article appears in the January 15, 1770²⁰ issue of the *Connecticut Courant*. The author indicates that in his next contribution further reasons will be given for the Hon. General Assembly's protection. Unfortunately I have not found the promised continuation, consequently the author's name does not appear. The quotation which heads this presentation is the same quotation found on the frontispiece of James Potter's oration delivered the last day of February 1780, in Sharon, on the Rise and Progress Physic. Hence I infer that if we had the continuation of this presentation and the author's name, we should find it was written by Dr. James Potter.

"Will a superior genius snatch the quill,
And save me on the brink from writing ill?"

Young

The Physician, No. 1

To The Public

Bodily health is so absolutely necessary in order to the enjoyment of any other of the gifts of nature or Providence, that all ages and nations have labour'd, with unremitted assiduity, to find means to preserve and restore, when lost, the most invaluable Blessing. Nor is health less necessary for any one who would do any great service for his country. Had a man the genius of an Alexander, Newton or Boerhaave, and at the same time struggling with the most tormenting gouty pains, or seiz'd with a raging fever or languishing under a consumption, it is obvious, that in either of these circumstances he would be in an ill situation to conquer the world, investigate mathematical problems, or preach physical lectures at the university of Lyden. A consideration of the importance of health and the proper means to preserve and restore it when lost, has induced sundry Princes, and some of the wisest and best men in all former ages, to take upon them the study and practice of the healing art; and because incompetent knowledge of the laws of the animal anatomy, and the nature and operation of medicines is absolutely necessary in order to qualify any one to act the part of a good physician, it has been the particular care of all the patriots and wise statesmen to encourage the study of physic. Were it needful I might here recite the various physical seminaries which have been instituted in all parts of the learned world down to the present day; but as

every one in the least acquainted with letters, must be sensible of the truth of these facts, shall therefore wave an enumeration, and proceed to say, that a consideration of the importance of what I have been speaking of, induced a number of gracious gentlemen belonging to the county of Litchfield, about five years ago, to form themselves into a medical society; and in order to accomplish their noble design, and facilitate the growth of physical knowledge, they made a number of resolves (a true copy of which is now lodg'd in the secretary's office with design to be heard by the new General Assembly at their sessions in May next) and gave invitations to all reputable Physicians to join them. In consequence of which, and by means of the salutary effects resulting from their conventions, their number is greatly augmented by additions from this and other neighboring provinces, and I will venture to say, that there is not a gentleman of generosity, and learning acquainted with this society but who is absolutely convinced of its utility and ardently wishes its prosperity. Indeed the benign influences which it is daily defusing around us are so conspicuous that they are seen and acknowledged even by the most insensitive. Shall now give a brief account of this society's proceedings. The society meet twice a year statedly, and oftener if occasion calls. The conventions are sometimes opened by an oration - - - after which, if any gentlemen are desirous to join the society, on their being well recommended by proper persons, as regular practitioners, they are received by a vote - - - after this, follows four dissertations on physic made by gentlemen previously appointed - - - next the candidates for physic themselves, who are examined by a committee in presence of the whole society (if they please) ask the candidates such questions as they think proper. Note here, these examinations are systematical, being correspondent to the method practiced by Boerhaave, president of the college of physicians at the university of Leyden. After the examination is over, the candidates are try'd one by one with respect to their qualifications - - - such as are found qualified are received by a vote into the society, and take - - - such as are not qualified are rejected. Must now inform that if any member of society makes any new discovery either in the study or practice of physic he communicates it at the next convention; and if anything occurs to him in his study or practice with he can't investigate, he proposes the case to the society and takes their opinion thereon. Thus far of the design and order of this society I shall in my next endeavor to point out the advantages that will arise from the Hon. Assembly's protection and the disadvantages which will necessarily result from no protection.

After this communication, addressed to the public, this notice appeared in the *Connecticut Courant*²¹ of April 16, 1770:

"Notice is hereby give to all the members of the Medical Corporation, that the last meeting stands adjourn'd to the Tuesday preceeding the General Election, and as matters of importance, will then be before the Corporation, 'tis hoped that all its members will duly attend.

Litchfield, 9th April."

The next notice we find is in the *Connecticut Courant*²² of January 1, 1771:

"Notice is hereby given to the members of the Medical Corporation of Litchfield County, that the next Convention is to be held at Litchfield Court-House, on the third Tuesday of January next: All the members are desired (though heretofore they have been very negligent) to attend said meeting, as matters of great importance are then to be transacted.

Thomas Russell, President.
Samuel Catlin, Clerk."

The final reference to a meeting appeared in the *Connecticut Courant*,²³ November 19, 1771:

"Notice is hereby given to all concerned, that the meeting of the Medical Corporation of the County of Litchfield, stands adjourned to Tuesday the 24th day of December, AD 1771, to be held at the town-house in Woodbury.

Test. S. Orton, Clerk."

This is the last notice on record of the society which thus far has come to light. No further notices appear in 1772 or 1773. Perhaps the impending Revolution and the war itself may account for the presumed inactivity until the appearance of the medical society of Sharon, July 5, 1779. There is evidence that this latter society continued its transactions for at least eleven years—into 1790. Thus in this early period Litchfield County was the centre of medical society activities more than any other part of the colony. Of all the members of either society, Simeon Smith was the only one who had the advantages of study in Edinburgh, which brought home to him the important role such societies could play in the striving colony.

Throughout the colony a large number of men sought falsely to obtain the dignity inherent in the medical profession. Litchfield County being in the most western part of the colony and remote from the earlier settled communities had among its in-

habitants many quacks and pretenders. It must have been discouraging to find men ignorant, having served no apprenticeship and without training rendering medical and surgical care, "who with a few Indian nostrums, a lancet, a glisterpipe, treacle water mixed with Roman bombast of *vena cava* and *vena porta* attack fevers, nervous disorders and broken bones, and by the grace of perserverance subdued nature, had helped their patients to a passage to the world of spirits before they were ready."³⁰ Yet in spite of this state of affairs the Assembly gave to the corporation none of the powers sought nor in any way inhibited the quacks and pretenders. Even in the more sophisticated County of New Haven, the newly formed Medical Society of New Haven, 1784 some 18 years later, "prayed the legislature to adopt such measures for the future regulation of our salutary art, as shall effectively support merit and discount ignorance and presumption." It would thus appear that not only in the western reaches but throughout the colony the need to combat ignorance, presumption and empiricism in the healing art was imperative.

In evaluating the accomplishments of The Medical Corporation in Litchfield, cognizance must be taken of the environment with which the daily lives of its members were surrounded. Transportation was largely by horseback with medical and surgical equipment in the saddle bags. The 1774 census of Litchfield stood at 2,559 and Sharon 2,012. Even in 1790 the population of Hartford was approximately 4,000, and of New Haven 3,000. No set of standards for the practice of either Physic or Surgery existed. Men studying under a physician as an apprentice relied upon the knowledge and skill of the preceptor whose character and manner, no doubt, cast their shadow over the pupil.

Many of the early practitioners were clergymen with an educated background and, though having little medical knowledge, they brought to the profession integrity, dignity and a scholarly approach. The angelic conjunction of divinity and medicine, to use Cotton Mather's phrase, had much to offer the healing art in its ministrations to both body and soul. Notable examples were Gershom Bulkley, Wethersfield; Jared Elliot, Killingworth; Phinehas Fiske, Haddam; Benjamin Gale, Goshen and Tim-

othy Collins. The latter, one of the founders of the Medical Corporation, graduated from Yale in 1718, was the first settled pastor of Litchfield, performing the duties of the Christian ministry for thirty years, and in 1752 was released from his pastoral charge to devote his efforts to the healing art until his death in 1777. These men, and the more scholarly physicians appeared in public with cocked hat and small clothes, characteristic of the profession.

Medical books were not easily acquired. Thus when Jonathan Williams, Yale 1722, died in 1738 his medical library consisted of Philip Woodhouse's *Modern Physician* and Thomas Morgan's *Principles of Modern Medicine*.³⁰ A rich medical library in the latter half of the eighteenth century probably would have included Cheselden and Monro in anatomy, Haller in physiology, Heister and Pott in surgery, and Boerhaave and Sydenham in medicine. It is doubtful if these were available to many of the men in the colony. Boerhaave was held, in the period under discussion, in the same reverence given during the early part of this century to Osler, and to Welch whose paternal and maternal ancestors Benjamin Welch and Ephraim Guiteau were both members of the society.

From the record now at hand we may conclude that The Medical Corporation in Litchfield maintained an active organization for about five years from January 1767 through 1771, having its regular conventions in January and June, with additional meetings as matters of importance arose. The principles upon which the society was founded were fundamental for the advancement of the healing art. The members chose to meet together in a spirit of honor, honesty and fidelity towards each other, and to encourage the presentation of medical discourses as well as observe and minute rare and uncommon occurrences in their daily practices. These medical pioneers could not have set before them more lofty aims, nor could they have striven to give to the profession in the colony a sounder foundation on which to build. To the early builders of our Connecticut medical heritage it would be rewarding could they know that in these same hills of the Taconic Range and its spurs, through the lovely village greens of Litchfield and Sharon, along the quiet Housatonic in Cornwall and Kent and

among the steeper reaches of Norfolk, some two hundred years later, men carry on the high devotion to Physic and Surgery which their forbears strove so diligently to attain. Our homage to the enduring spirit of these forebears!

Samuel Bard's, *A Discourse upon the duties of the Physician*, with some sentiment on the usefulness and necessity of a Public Hospital (A. J. Robertson, New York, May 1769) is credited as being the first code of medical ethics in America. Oliver Fuller's oration, a code of ethics, antedates Bard's by two years. The following paragraph from Bard's discourse conveys a comparable charge to medical students:

"But it is to you, gentlemen, who are candidates for medical degrees, that I mean in a more particular manner to address my present discourse; receive then my thanks for the Honors you have reflected upon me, and as both for your sakes and our own, I cannot but be anxious for your future Reputation; and let me once more, before we part, request your Attention for a few Moments, whilst I endeavor to explain to you the weighty duties of your Profession—a Profession, in the Practice of which, Integrity and Abilities will place you among the most useful, and Ignorance and Dishonesty, among the most pernicious members of society.

"And be not alarmed if I set out with telling you that our Labours must have no end. No less than Life and its greatest Blessing Health are to be the Objects of your attention; and would you acquit yourselves to your own consciences, you must spend your days in arduous Enquiries, after the means of rendering those of others long and happy."

I am greatly indebted to Miss Esther Cook, Connecticut State Library, and to Miss Gertrude Annan and Miss Alice Weaver of the New York Academy of Medicine for their generous help.

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Tennessee Has Highest M.D. Graduate Record

The University of Tennessee Medical School at Memphis turned out more doctors in 1956 than any of the other 76 four-year approved medical schools in the United States.

The Tennessee school, which operates on a year around basis and admits several classes annually, graduated 199 young M.D.'s during 1956. It was one of six schools graduating more than 150. The other five and the number of 1956 graduates were:

Michigan at Ann Arbor, 189; Jefferson at Philadelphia, 171; Illinois at Chicago, 159; Texas Medical Branch at Galveston, 151, and Harvard at Boston, 151.

Special Article

THE COMMUNITY PSYCHIATRIC CLINICS* IN CONNECTICUT

Their Activities and Needs

JAY KATZ, M.D., and RICHARD H. SCHLESINGER, M.S.W., *New Haven*

IN June 1956, the Community Clinics Advisory Committee of the Connecticut Association for Mental Health sent a questionnaire to 16 community psychiatric clinics† in the State. The committee asked for information about the clinics' personnel, additional staff requirements, methods developed

Dr. Katz. *Instructor of Psychiatry, Yale University School of Medicine; Executive Officer of the Psychiatric Clinic, Grace-New Haven Community Hospital*

Mr. Schlesinger. *Director of Field Services, Connecticut Association for Mental Health, Inc.*

*"A Community Psychiatric Clinic is a medical organization established primarily to treat the mental and emotional ills of individuals. It is directed by a psychiatrist. As part of its function, a Community Psychiatric Clinic may offer diagnostic, evaluative, and consultative services to individuals and to other community agencies. The clinic is responsible to the rest of the community, not only for providing the clinic services to individuals and to other agencies, but also for assuming leadership in community mental health education and interpretation. The community participates in the management of the clinic through a citizens' board of directors or advisory committee." (From "A Guide for Establishing Community Psychiatric Clinics," published in July, 1956 by the Connecticut Association for Mental Health; cf. page 5.)

†Data from the following clinics were included in this paper: seven children's clinics: Child Psychiatry Unit of Yale University Child Study Center, Clifford W. Beers Guidance Clinic, Hartley-Salmon Clinic, Mental Hygiene Clinic of New Britain Society for Mental Hygiene, Salisbury Health Center, Stamford Psychiatric Clinic for Children, and Child Guidance Clinic of Waterbury; three adult clinics: New Haven Dispensary Psychiatric Clinic, Stamford Hospital Psychiatric Clinic, and Waterbury Hospital Out-Patient Department Psychiatric Clinic; six clinics serving both adults and children: Bridgeport Society for Mental Hygiene, Neuropsychiatric Clinic of the Greenwich Hospital Association, Hartford Hospital Mental Hygiene Clinic, Norwalk Hospital Psychiatric Clinic, St. Francis Hospital Psychiatric Clinic, and Community Clinic of the Silver Hill Foundation.

There are 33 outpatient psychiatric clinics in the State. Not included in this survey, because they are not community clinics in the same sense as defined above, are the five clinics of the Commission on Alcoholism, the five State Hospital Outpatient Clinics, the Southbury Training School Outpatient Clinic, the Yale University Student Mental Hygiene Clinic, and the Demonstration Child Guidance Clinics of the Division of Community Services, State Department of Mental Health. The data from one community clinic was not available at the time this report was written.

SUMMARY

The expansion of existing community psychiatric clinics in Connecticut has not kept pace with the number of patients needing and seeking psychiatric help. In half the clinics patients waited at least one month before being seen for their first evaluative interview, and at least three months before commencing treatment.

Additional psychiatrists, psychiatric social workers and psychologists are needed to make more treatment time available and to increase other community services, such as consultations with schools, courts, and welfare agencies.

Financial support will have to be greatly augmented, both for the expansion of the professional staff and for increases in salaries where they are not in line with the national competitive market. Such financial support will have to come from the fund raising activities of the communities and greater contributions from the State.

These steps will have to be taken before the community psychiatric clinics can exercise to a fuller extent their expected functions as responsible agencies in their communities.

for meeting requests for service from the community, and future needs and plans. This paper presents the findings of this study.

1. PRESENT CLINIC ACTIVITIES

During the past year, the 16 clinics absorbed close to 4,000 patients (table I).

TABLE I

SERVICES OFFERED TO PATIENTS BY SIMILEN COMMUNITY CLINICS DURING 1955

Total patients during year.....	3,922
Number of person interviews.....	29,171
Number terminated during year	
Total	3,082
Under 18 years.....	1,599
Above 18 years.....	1,483
Number carried over at end of year.....	1,149
New admissions during year.....	2,654

The majority of patients accepted for treatment were seen in once a week psychotherapy. The number of patients who terminated treatment by the end of the year was 3,082 and 1,149 patients were carried over. There were 2,654 new admissions. The patients were seen in over 29,000 interviews lasting fifty minutes to one hour. Approximately one third of the patients were referred to other agencies and hospitals after the diagnostic work-up. Eight of the clinics reported that their limited treatment facilities made it necessary to refer elsewhere a considerable number of patients who otherwise might have been absorbed more appropriately by these clinics. Table II summarizes the diagnostic classification of the patients who terminated treatment during the year.

In addition to seeing patients, the clinic staff spent considerable time in consultation with other community agencies to discuss with them referrals to and from their clinics. Seven clinics carry on training programs for professional personnel. A few clinics are engaged in research, some of their projects

TABLE II

DIAGNOSTIC CLASSIFICATION OF PATIENTS TERMINATED DURING YEAR

DIAGNOSIS	PATIENTS*			
	UNDER 18 YEARS		ABOVE 18 YEARS	
	NUMBER	PER CENT	NUMBER	PER CENT
Psychoneurotic reaction	97	7.3	496	34.3
Psychotic reaction	25	1.9	282	19.5
Personality disorder	158	11.8	308	21.3
Transient situational reaction	321	24.0	33	2.3
Psychophysiological reaction	6	0.4	64	4.4
Organic brain syndrome	61	4.4	74	5.1
Mental deficiency	81	6.1	9	0.6
No psychiatric disorder	151	11.3	6	0.4
Undiagnosed	438	32.8	176	12.1
Total	1,338	100.0	1,448	100.0

*The data from three clinics were not available

being specifically concerned with community problems.

II. PRESENT STAFF

In describing the present staff of the 16 community clinics, the 14 clinics which are not affiliated with a university (table III) have been separated from the two clinics, both in New Haven, which are affiliated with Yale University School of Medicine (table IV).

Only two full time psychiatrists are associated with the 14 clinics; the others are staffed by part time psychiatrists. Of these, eight have only one part time psychiatrist. The average weekly available

TABLE III

PRESENT STAFF IN FOURTEEN COMMUNITY CLINICS

		PSYCHIATRISTS		SOCIAL WORKERS		PSYCHOLOGISTS		CLERICAL	
Full time		2		16		4		16	
Part time		12		5		16		7	
Number of staff	1	8 clinics		8 clinics		12 clinics		7 clinics	
	2	2 clinics		5 clinics		1 clinic		6 clinics	
	More than 2	4 clinics		1 clinic		1 clinic		1 clinic	
		NUMBER		NUMBER		NUMBER		NUMBER	
		HOURS	OF CLINICS	HOURS	OF CLINICS	HOURS	OF CLINICS	HOURS	OF CLINICS
Available total staff time per Clinic per week		1-10	2	21-40	8	1-10	4	21-40	7
		11-20	4	41-60	2	11-20	4	41-60	3
		21-30	4	61-80	3	21-30	1	61-80	3
		31-40	1	Over		31-40	3	Over	
		Over		81	1	Over		81	1
		41	3			41	2		

TABLE IV
PRESENT STAFF IN TWO COMMUNITY CLINICS WITH
UNIVERSITY AFFILIATION

	PSYCHIATRISTS	SOCIAL WORKERS	PSYCHOLOGISTS	CLERICAL
Full time	15	5	0	5
Part time	8	3	4	1

psychiatric time is 29 hours per clinic and in over half the clinics is less than 24 hours. Since the psychiatrist is also the director of the clinic, a considerable portion of his time is taken up by administrative duties. Therefore, treatment by psychiatrists is minimal in most community clinics.

The two university-affiliated clinics have over seven times as many full time psychiatrists and almost as many part time psychiatrists as all the other 14 clinics combined. Of course one of the major reasons for this large staff is the extensive training program which is carried on by the department of psychiatry, and the majority of the staff members are residents in their second year of training. However, it also points out that staff is attracted to clinics where the possibility for additional training and research exists and that community clinics may have to create such opportunities in order to help attract competent personnel.

One of the two university-affiliated clinics has a full time staff of 12 psychiatrists which represents the largest staff it ever had. Only with this increase has the clinic recently been in a position to evaluate and treat all patients who have been referred to it without resorting to any of the temporizing measures which will be discussed below. However, it should not be implied that the clinic has reached an optimal level of functioning as far as staff requirements are concerned. The limit of psychiatrists, social workers, and psychologists needed in a community clinic has never been tested. It may well be, once the present situation of the clinic becomes more widely known, that referrals will again outstrip the available treatment time. However, a comparison of the staff in the 14 community clinics with the two university-affiliated clinics illustrates clearly that the former are woefully understaffed to meet the psychiatric needs in their communities.

The staff situation is equally critical as far as psychiatric social workers are concerned. At present almost all the clinics have full time social workers but a majority of the clinics have only one social worker (table III). The social workers fill

many important functions in the clinic setting. Their major area of responsibility is in interviewing patients and their families, and providing case work treatment. In addition they work in other important areas, such as interagency relations, consultations with schools, and conferences with probation officers, public health nurses, and other referring sources. Almost all of the clinics report that their social work staff is inadequate to meet these needs.

The functions of the clinical psychologists have also expanded, but only two of the clinics have full time psychologists and eight of the clinics have the services of a psychologist for only six to twenty hours a week (table III). A majority of the clinics state that they require additional psychologists on their staffs.

There are a number of budgeted staff vacancies, some of which have been unfilled for more than a year. Six openings are listed for psychiatrists and five for psychiatric social workers. Since the survey was completed a number of additional vacancies have been created because staff members have received more attractive financial offers. It is true that the available salaries are often not remunerative enough to attract competent professional personnel. It is also likely that the insufficient stimulation and hectic activities in the presently understaffed clinics contribute considerably to the difficulties in attracting personnel.

However, the vacancies are also influenced by the scarcity of trained professional personnel throughout the country. There exists a nationwide competitive market for available staff members, and other agencies offer substantially higher salaries and more attractive working conditions than many of our community clinics. Positions could also be made more attractive if the clinical programs included greater opportunities for participation in research projects and for in-service professional training.

III. FINANCIAL STATE

The annual budget of the sixteen clinics is \$576,024 (table V).

The income from fees is close to 10 per cent. The largest single contribution is made by the communities through their fund raising activities; almost a third of the present clinic expenses are met by them. The hospitals, mostly by providing free housing for the clinics, contribute the equivalent of 20 per cent of the total budget. State funds

amount to 15.8 per cent and federal funds to 12.5 per cent of the clinic income.

TABLE V
INCOME OF THE SIXTEEN COMMUNITY CLINICS

INCOME FROM	AMOUNT	
	IN DOLLARS	IN PER CENT
Fees:		
Patient	46,362	8.1
Public agencies	6,395	1.2
Tax Funds:		
City, town, county.....	4,300	0.7
State	90,819	15.8
Federal	71,921	12.5
Community Chest or Fund.....	177,982	30.9
Individual gifts	17,733	3.1
Foundations	33,600	5.8
Hospitals	117,630	20.3
Other	9,282	1.6
Total	576,024	100.0

IV. ADDITIONAL STAFF NEEDS

All clinics requested additional staff. The data of the survey (table VI) indicates that these requests were conservative, in that they tried to strike a balance between financial considerations and the service needs determined by the clinics. The re-

TABLE VI
ADDITIONAL STAFF REQUESTED BY 16 COMMUNITY CLINICS

	FULL TIME	HALF TIME
Psychiatrists	11 (9 clinics)	6 (4 clinics)
Social workers	24 (13 clinics)	1 (1 clinic)
Psychologists	7 (6 clinics)	4 (4 clinics)
Clerical	18 (10 clinics)	2 (2 clinics)

quested increase for psychiatric time would give most clinics only one full time psychiatrist, i.e., including their present staff. The social work staff, inadequate as it is in meeting the many demands made on it, would only be doubled. An increase in the number of psychologists is urgently needed. In child guidance clinics diagnostic studies often cannot be completed because of delays in the administration of psychological tests.

V. PRESENT PROBLEMS

At present, the clinics cannot absorb all the patients appropriately referred to them. They have had to find various solutions to bridge the gap between the psychiatric needs of the community

and the existing resources of the clinic; but none are considered adequate. Here are some typical comments: "We are just able to keep the situation under control;" or "none of them have really answered the community needs. A waiting list and closing intake are the least desirable methods;" or "community demands had to become adjusted to the available facilities. The referring agencies are aware of the limitations of the clinic and do not make referrals."

Much time and effort is uneconomically expended in making referrals to other agencies which only partially meet the needs of the patients who instead should have been treated by the community clinics. The intake procedures often have to be brief and superficial. Treatment time is scarce so that in some clinics only patients are accepted who can benefit from a brief treatment experience. Yet the clinics felt that, however inadequate, these procedures are attempts to meet the needs of as many patients as possible on at least some level.

A few clinics are so unhappy with the inadequacy of such temporizing and superficial services that they close intake periodically to all patients. Others have a waiting list for intake. A few clinics at least see the patients in order to discuss briefly with them their problems and how they might manage during the waiting period. This frequently leads to much frustration for both patient and staff; the door has been opened but there is no room behind it. Often it takes the patient a long time before he ventures to seek psychiatric help and now he feels rebuffed at the start. A considerable number do not return for treatment when eventually there is an opening for them.

All clinics, unless they close intake, have a waiting list (table VII).

TABLE VII
WAITING PERIOD FOR INTAKE AND THERAPY

WAITING PERIOD	INTAKE	THERAPY
Less than 1 month.....	4	3
1-3 months	5	5
3-6 months	3	2
6-12 months	0	5
Total	12*	15

*Four clinics close intake periodically

In five clinics the waiting period for intake is one to three months and in three it is three to six months. The waiting period for therapy is even longer; in

five clinics patients have to wait six to twelve months before they can be assigned for treatment.

The waiting list is a continual source of frustration to the staff. The staff constantly has to make administrative decisions which they should not have to make: such as, is one patient in more urgent need of treatment than another, or should a patient's treatment be curtailed to make room for another?

Yet, despite these difficulties the clinics have neither given up nor become rigid in their policies. Instead, they have improvised whenever necessary and looked for new solutions. This has been no mean achievement.

VI. THE NEEDS

The overall needs of the community clinics are difficult to assess since the community demands have artificially been held in check by the limitations of present facilities. A number of clinics reported that many agencies, schools, and private physicians have not referred as many patients as they wanted to because they are aware of the long waiting lists.

What is clear though is that the demand for help with emotional problems is increasing in all communities. The stigma which for so long has been attached to anything psychiatric is slowly fading away, at least as far as community-based treatment is concerned. Aside from the increased efforts in educating the public in recent years, the word of mouth recommendations by former patients and their families have contributed in large measure to this development. More patients come to treatment on their own and many more are referred by public agencies, schools, and courts, and physicians in private practice. The patients' needs are usually immediate and they find the waiting period hard to take. In the lower socio-economic groups it often

feeds into their already all too pervasive convictions that nobody really wants to listen to them.

Table VIII lists the additional needs of the clinics, according to categories volunteered by them. Financial support is of course the cornerstone for the expansion of the community clinics and this support must be forthcoming through a partnership between the State, the community, and private resources. For a long time the clinics have had to struggle each year, not only with inadequate funds but also with the uncertainty of the extent of their financial support. This has made long-range planning difficult and steps should be taken to work out a formula which will make support more secure both on a local and State level. Last year the State of Connecticut contributed 15.8 per cent of the annual budget of the sixteen community psychiatric clinics. To allow for the needed expansions of the clinics the State's contributions will have to be increased. However, it may also be advisable to develop a formula which will provide a more valid basis for the allocations of State support to the clinics. This will require careful study since perhaps such a formula may have to be flexible in order to take into account special community problems.

Most of the money is needed for additional professional salaries. However, the national competitive market for professional staff makes it necessary to reevaluate present salary scales, as well as fringe benefits, to bring them in line with those of other agencies and clinics. With an increase in staff the clinics will be able to absorb more patients, give more adequate services to other community agencies, and, where appropriate, expand their professional training programs, and initiate clinic and community-centered research projects.

There is an acute shortage of professional personnel in the State, and the community clinics for many reasons should consider it one of their functions to train additional staff.* At present 6 community clinics have training programs in one or more of the professional specialties (table IX). Nine clinics indicated that they want to initiate or expand their training programs.

TABLE VIII
ADDITIONAL NEEDS OF CLINICS*

1. Financial support.
2. Staff.
3. Treatment time.
4. After care program - State hospital patients.
5. Research time.
6. Training program for professional personnel.
7. Housing for clinics.
8. Psychiatric services in schools.
9. Adult day care program (especially for the aged)
10. Residential treatment facilities for disturbed children.
11. Psychiatric services to public agencies.
12. Marriage counselling.

*In order of number of requests made.

**There are serious shortages of professional personnel necessary in community treatment of mental illness. Out-patient psychiatric clinics are few and large areas of the State have none. There is a great lack of psychological and social services in schools where mental disorders are often manifested in an early stage." (From "The Program of the Department of Mental Health 1957-1959," Hartford, Connecticut.)

TABLE IX
TRAINING PROGRAMS IN COMMUNITY CLINICS

TRAINING PROGRAMS IN CLINICS FOR	EXISTING	CONTEMPLATED
Psychiatrists	3	5
Psychologists	5	4
Social workers	6	8

Lack of funds is the principal stumbling block, and at least one clinic may have to discontinue its training program because of inadequate financial support. Such programs will eventually decrease the shortage of staff by attracting and keeping professional people in the State; they will increase the services given to the community by the utilization of the personnel in training; and they will create a more stimulating atmosphere in the clinics.

More time for research will have to be made available. There is still much to be learned in the area of community psychiatry. For instance, we have failed so far to absorb in treatment a significant number of patients from the lowest socio-economic class, despite the fact that they represent the largest group of patients referred to adult clinics. It is important that the clinics examine from time to time what they are doing, where they are going, and whether they meet the needs of their communities; but this requires planning and time.

Nurse Midwifery in America

Herbert Thoms of Hamden, writing editorially in a recent issue of the *American Journal of Obstetrics and Gynecology*, offers strong arguments in favor of developing a nurse-midwife system in this country which shall enhance the practice of obstetrics. To quote Dr. Thoms: "The challenge today to American obstetrics is that every woman in the land whose destiny it is to produce the citizens of tomorrow is entitled to the best care that scientific obstetrics can give, and this means for her not only a safe delivery but one of satisfaction to her as an individual. This involves an individualized type of care during pregnancy and parturition which will afford her full opportunity to prepare herself physically and mentally for her part in childbirth and for her role as a mother."

It is true that with the rising birth rate more than four million women will need obstetrical care in the next and in each succeeding year. This fact

will impose a heavy burden upon the obstetricians if they are properly to care for all these women. The Maternity Center Association of New York and Dr. Eastman's program at Johns Hopkins Hospital would seem to prove that well trained nurse-midwives can make a valuable contribution to maternity care if utilized as a part of a team.

One thinks quite naturally of the nurse midwife system in England referred to in Dr. Thoms' editorial. To the American doctor the English system, especially under the present National Health System, falls short of what he would desire, but if this nurse-midwife system becomes acceptable in our country it will be standardized on a high plane and place the status of the nurse-midwife on a level with that now enjoyed by nurses as specialists in public health, pediatrics, and mental hygiene nursing.

Who will be the next to augment this experiment?

National Organization Set Up to Promote Jenkins-Keogh Plan

Seven associations, including the American Medical Association, have banded together into a national organization to promote legislation for establishment of voluntary pension plans for the self-employed, the Jenkins-Keogh proposal long supported by the AMA. Name of the new organization is "American Thrift Assembly for Ten Million Self Employed." Its headquarters are in Washington, at 1025 Connecticut Avenue. F. Joseph Donohue, Washington attorney, is national chairman.

In addition to the AMA, charter members of the new group are American Bar Association, American Institute of Accountants, American Retail Federation, National Association of Real Estate Boards, American Dental Association, and National Association of Retail Druggists. Its steering committee will present to the public and Congress the viewpoints of some 20 national associations representing business, agriculture and the professions.

The objective is passage of legislation to authorize deferment of income tax on a portion of income if put into a retirement or annuity program, with tax to be paid as the money is received back in the form of retirement benefits. Under present law, corporations need not pay taxes on money put into retirement plans for their employees, but the self employed are denied this advantage.

NEWS FROM WASHINGTON

Senators Propose Amendment to PA Medical Care Arrangement

In response to requests from a number of States, 19 Senators have introduced a bill to change a social security amendment—scheduled to go into effect July 1—that deals with medical care of public assistance recipients. In essence the new bill would permit States to continue their present medical care programs for public assistance cases without change, and at the same time to use all money available after July 1 under the new program for direct payment to the vendors of medical care. One of the 19 is Senator Bush of Connecticut.

Specifically the bill now before the Senate would:

1. Permit States to continue budgeting funds for medical care in the form of payments to recipients, and continue the old pooled fund vendor payment arrangements.
2. Permit them in addition to receive federal money to the extent of \$3 per month for each adult public assistance recipient and \$1.50 for each child for medical care.

Three Montana Democrats, Senators James E. Murray and Mike Mansfield and Representative LeRoy Anderson, introduced a bill which would broaden "medical care" for income tax purposes. Sums paid to convalescent homes or rest homes would be deductible as medical expenses, provided the patient was totally disabled physically or too old to be gainfully employed. Bills are S1275 and HR5099.

New Health Institute Proposed: Would Deal in Radiation Problems

Two Oregon Democrats, Senator Neuberger and Representative Porter, have introduced identical bills to set up the eighth institute at the National Institutes of Health. It would be known as the National Radiation Health Institute and its basic job would be to coordinate research in atomic and nuclear radiation effects on human health.

The bills provide for an Office of Radiation Health Control which would distribute through the States, physicians, hospitals and other groups cards for individuals recording each person's exposure to

measurable amounts of radiation. This would be voluntary and would include exposure from x-rays while undergoing medical or dental examination and treatment. The sponsors said such a plan had been proposed last year by the National Academy of Sciences but nothing had been done about it.

The institute would conduct intramural research and make grants for studies by medical schools, hospitals, laboratories and individuals. Traineeships also are provided. Applications would be screened by a National Advisory Radiation Health Council. The bill does not spell out how council members would be selected.

Folsom Wary of Bill for Free Hospitalization at Age 65

Because it "opens up a problem" and "moves into the area of compulsory health insurance," Secretary Folsom believes the country should go slow on government paid hospitalization at age 65 for OASI beneficiaries. A bill on this subject, originally a Truman-Ewing idea, is now before Congress and has labor support. At a news conference the secretary noted that the Social Security Act had been extensively amended last year, and said "I hope we will not get into it again this year." The Secretary also:

1. Said there would be no Presidential Health Message this year, and the HEW would offer only two major health bills, for aid to medical schools and to permit small companies to pool resources to experiment with unusual risks in health insurance.
2. Explained that HEW had not reached a decision on whether to back federal mortgage guarantees for health facilities.
3. Indicated the department will return to the treasury an undetermined amount of money appropriated for medical research because it will not be possible to spend it wisely; the amount will be in the millions.

Social Security Administrator Schottland said he expected that about half the States would be prepared to participate in the new medical care program for public assistance recipients when it goes into effect July 1.

The Medicare Program

The Army's Office of Dependent Medical Care, handling the new program that offers private medical care to service families, is working on some long- and some short-range plans of importance to State Societies.

To meet a problem coming up in the next few months, the office is notifying States that contracts for physicians' services, negotiated through the State Societies last fall, will be extended automatically when their expiration date of July 1 arrives. However, there is no definite time period set for any of the extensions; each contract will be continued in effect until that particular State's agreement has been renegotiated.

When the contract is extended, according to Maj. Gen. Paul I. Robinson, head of the Office of Dependent Medical Care, it will be possible to make necessary adjustments, but he hopes not too many changes will be asked at that time.

Then, after July 1, each State will be given a 60 day notification before Defense Department makes its final audit covering the period from December 7, 1956, when the program went into effect, through June 30, 1957. This audit has been promised in each State before renegotiation starts.

Both the State fiscal agents and Gen. Robinson's staff should be well prepared for renegotiations when the time arrives. No renegotiations will be undertaken until January, 1958. They will continue for most of next year, on a tentative schedule that calls for handling about five contracts per month.

Under this tentative arrangement, the contract with the Connecticut State Medical Society will be renegotiated during the month of May. All State medical societies are participating, with two exceptions: Rhode Island, where the Army is paying doctors directly, and Ohio, where the Army has contracted with an insurance company to handle the physicians' Medicare.

Blue Cross Billings for Medicare Running Higher

Sizable difference between Blue Cross and commercial (Mutual of Omaha) billings for hospital care of servicemen's dependents has Medicare officials in Washington scratching their heads. Between program's inception on December 7, 1956,

and January 31, 1957, Medicare approved \$200,-526.78 in claims, filed by Blue Cross, to pay for 7,339 days inpatient care. Mutual of Omaha's billings to March 1 are up to December 31 only, totaling \$13,103.77 for 769 days hospitalization. Thus, Blue Cross average is \$27 plus, compared with \$17 plus for the commercial fiscal agent's.

The much smaller Mutual volume, geographical variations, unknown factors relating to patient selection—these may account, at least in part, for the big differential. But Medicare officials concede this is mostly rationalization, and are going to do some comparative analysis to find a clear-cut answer.

Cost of Medical Care in the U. S.

When the various parts that go into the Nation's health bill each year are added up, the total is staggering. Estimates of private and public spending include the cost of everything from patent medicine and toothpaste to surgeons' fees. Private care for the country in 1955 was placed at \$11.2 billion, while public care (federal, state and local) was estimated at \$3.9 billion. The following figures for private care costs are for 1955. \$3.4 billion for physicians' charges. \$3.7 billion for hospital charges. \$2.3 billion for charges for drugs and appliances. \$1.8 billion for other charges, including nursing, etc.

Health and Medical Resources

The medical "plant" that provides the country with the finest care of any nation is equally impressive when viewed statistically. In one area, that of medical school graduates, bare statistics fail to tell the whole story. They do not, for instance, reflect the increased utilization of physicians' skills and the advance of medical knowledge in treatment of patients. 225,579 physicians in U. S. in January, 1956. 1,604,000 hospital beds in U. S. in 1955. 430,000 professional nurses in 1955. 300,000 practical nurses, attendants, nurses' aids in 1955. 4,735 medical school graduates in 1930. 5,275 medical school graduates in 1940. 6,135 medical school graduates in 1950. 6,845 medical school graduates in 1956.

Voluntary Health Insurance

Another development of great importance in the furnishing of medical care has been the growth of voluntary health insurance. Twenty years ago the number of persons covered by some form of health

insurance was only 1.5 million. When the drive was on for compulsory health insurance in 1949, just over 50 million persons were covered by voluntary insurance. Organized medicine contended then that voluntary coverage would expand, thus obviating the need for government insurance. The figures below prove this was a good estimate of the situation. 110,000,000 persons now covered for hospital charges. 92,000,000 persons now covered for physicians' charges for surgery. 55,000,000 persons now covered for physicians' medical charges in hospitals. 10,000,000 persons now covered for physicians' home and office call charges. 10,000,000 person now covered for major medical expenses (catastrophic) compared with 1,200,000 covered in 1953.

Public Assistance

A part of the Social Security Act, but a separate administrative operation, the public assistance program also was enacted in 1935. Its basic purpose was to assist States in providing subsistence for destitute families. From the beginning, the States have contributed a portion of funds for the various categories of recipients. Federal appropriations 20 years ago were about \$209 million annually. Now they have increased more than sevenfold, so that the appropriation for the current fiscal year approximates 1.5 billion. There are four programs: aged, blind, permanently and totally disabled, dependent children.

Until amendments last year, unspecified federal-state funds were paid out for medical services of the needy. An educated guess has been that between \$90 and \$100 million of federal money has been going into such medical payments. A more accurate estimate should be forthcoming as a result of the 1956 amendments. These amendments set up a new category of federal-state payments for medical care over and above the old subsistence payment limits, with medical payments going directly to the physician, hospital, druggist, clinic or nursing home.

5,100,000 persons get monthly public assistance checks—medical costs included.

Under new law, direct medical payments are to be made in behalf of assistance recipients to physicians, nursing homes, hospitals, and for drugs. These direct payments will probably exceed \$200,000,000 and could reach \$300,000,000 by 1958.

Veterans

Another vast program with high demands on the federal budget is that for veterans medical care. The policy of the Federal Government is that war time veterans with service incurred disabilities are entitled to the best medical and hospital care that can be provided. The American Medical Association supports this policy. Congress in June, 1924, authorized VA to admit indigent nonservice connected veterans when there were spare beds. By 1957 roughly 75 per cent of all cases treated in VA hospitals were for injuries and diseases not originating during or aggravated by military service.

Now the problem is becoming more complicated as the veteran population grows older (World War I veteran in VA hospitals averages age 62) and becomes subject to chronic illnesses. Demands increase for use of VA facilities. Today VA requires: a full-time staff of over 4,600 physicians; 2,247 residents; 11,000 part-time consultants; and thousands of doctors on a contract basis for the agency's home-town care program.

22,599,000 total number of living veterans as of January, 1957. 121,865 total number of VA hospital beds as of January, 1957. 111,540 number of patients in VA hospital facilities on an average 1957 day. \$619,614,000 will be spent by VA for inpatient care in fiscal year 1957. \$82,638,000 will be spent for outpatient care in fiscal year 1957. More than 2 out of 3 veterans treated in VA hospitals are treated for nonservice connected conditions.

Health Bills Introduced in Congress

National legislators have not held back on the sponsoring of many health and medical bills. They cover just about every phase of medicine and human welfare. Most of them, of course, never get past committees. But as an indicator of the growing interest in health legislation these figures on bills introduced are illuminating: 250 measures, 1951-1952, 82nd Congress; 407 measures, 1953-1954, 83rd Congress; 571 measures, 1955-1956, 84th Congress.

Potential Beneficiaries of Federal Medicine

Some of the greatest activity in the health field has involved laws and amendments to laws that widen the scope of medical care for federal beneficiaries. The very latest is Medicare voted last year

for military dependents. Today nearly one out of every four persons, including over 22 million veterans, is eligible to receive at no cost to them some degree of medical care from the Federal Government. 22,599,000 living veterans as of January 1, 1957. 5,200,000 military personnel and their dependents. 300,000 beneficiaries of the Public Health Service, including 200,000 seamen, but excluding beneficiaries of Federal Employees' Compensation Act and Indians. 5,100,000 public assistance recipients. 370,000 Indians and Alaskan natives receiving care in 56 federal hospitals or in private facilities under contract. 4,000,000 beneficiaries of the Federal Bureau of Employees' Compensation Act (at-work injuries only).

48,627 PHS hospital admissions in 16 hospitals in 1956. 1,042,000 outpatient visits in 121 PHS outpatient facilities during 1956. Foreign Economic Aid Programs (entirely U. S.) and the World Health Organization (U. S. largest contributor) give limited health care in 92 foreign countries. Example 25,300,000 children were vaccinated in 1956. 7,000,000 federal employees and their dependents (will be eligible for health care if proposed legislation is enacted).

Federal Health Spending

Under the impetus of new legislation enacted during the last few years—and particularly the new emphasis on medical research—the federal health budget is rising steadily. Bills introduced in the present (85th) Congress seek to expand many existing programs or set up new ones. The following table gives the total federal health bill for the current and last fiscal year and a breakdown of health spending for the top three departments of government.

	FISCAL 1957	FISCAL 1956	INCREASE
Total, all agencies	\$2,558,719,168	\$2,268,826,576	12.8%
Veterans' Administration	\$ 825,024,300	\$ 792,185,800	4.4%
Department of Defense	\$ 790,105,000	\$ 818,104,500	
Department of HEW	\$ 772,661,800	\$ 526,935,400	46.6%

Social Security

Of all the programs of government enacted in the last several decades, none has had greater impact on the population or has been subject to more liberal-

izing amendments than the Social Security Act of 1935. It began on a relatively modest scale, with retirement payments of up to \$10 a month for wage earners who reached age 65. At that time there were no benefits for the surviving spouse and children.

Now, 22 years later, the law has been amended to include: (1) survivorship benefits, (2) maximum monthly family survivorship payments as high as \$200, and (3) a program enacted in 1956 and effective this July 1 for payment of social security benefits to disabled workers at age 50. Efforts continue to be made to amend the law, including a program of free hospitalization of the aged, disability benefits at all ages, and compulsory national health insurance. Statistics on the program as it exists today: 9,250,000 persons received OASI monthly checks in January, 1957; 70,000,000 wage earners are covered and being taxed; 9 out of 10 persons in the U. S. are primarily "insured" or are their beneficiaries; \$22,519,000,000 in U. S. bonds in OASI Trust Fund; payments from the OASI Trust Fund and contributions to it are now about equal; tax rate is 2 1/4 per cent for employees and employers (4 1/2 per cent total); 3 3/8 per cent for self employed. Under present law, 1975 rate will be 4 1/4 per cent for employees and employers (8 1/2 per cent total); 6 3/8 per cent for self employed. Under a 1956 law, permanently and totally disabled persons aged 50-65 can get payments equal to retirement payments. Over 1,000,000 inquiries already have been made for disability payments or "disability freeze;" about one half of the more than half a million formal applications have been approved.

Labor organizations propose a \$6,000 tax base on which contributions would be computed, instead of the present \$4,200 base.

AFL-CIO Sets Goals On New Health Legislation

Executive Council of AFL-CIO, before concluding its meetings recently in Miami Beach, adopted the report of social security committee which fixes policy of organized labor on health and welfare issues. Taking a realistic approach, the Council confined its legislative recommendations to objectives whose attainment this year or next is quite within realm of possibility. It did not even mention compulsory national health insurance. What this country needs, according to labor's policy-making body, are the following:

Federalized hospital and nursing home care for persons receiving social security retirement benefits; also, extension of hospitalization and surgical services to recipients of OASI survivor benefits.

Government grants for construction, expansion, equipment and maintenance of training and research facilities in schools of medicine, dentistry, nursing and ancillary professions. Also, establishment of undergraduate scholarships.

Grants and low interest loans to stimulate development of direct service, nonprofit medical care prepayment plans.

Contributory medical care insurance for Federal employees and their dependents, with U. S. bearing at least 50 per cent of premium cost.

Board of Regents Named for National Library of Medicine

A 10 man board of regents has been nominated by President Eisenhower to guide the new National Library of Medicine. One of the responsibilities of the board will be to recommend the site for a new building. The building was authorized by Congress, but construction funds were omitted from the Eisenhower budget.

Sums Paid to Workers for Health Insurance Taxable

A ruling published by Internal Revenue Service clarifies one phase of premium payments for health insurance coverage. Advice had been requested as to whether sums paid regularly by a company to its workers, to be used expressly and exclusively for medical care and hospitalization premiums, were to be considered as "wages" for tax purposes. IRS previously has ruled that an employer's contributions for health insurance are not wages, when channeled directly into the prepayment plan or fund. But in this instance, the earmarked money was going into the workers' pay envelopes, by terms of an agreement between an employers' association and an employees' union.

Such payments constitute wages, according to IRS ruling, regardless of fact that union assumes responsibility for having members apply this money to prepaid health insurance coverage. Accordingly, the sums are includible as gross income and subject to deductions for income, unemployment and social security tax purposes.

"The fact that the union assumes responsibility for the disposition of such payments by the employees and the purchase of hospitalization and surgical insurance is immaterial," says ruling.

Army Medical Inductees Get 3 Month Duty Delay

Its manpower requirements having changed since it requested Selective Service several months ago to supply 250 physicians in February, 1957, Army is postponing their orders to active duty. These doctors, last to be called up involuntarily under doctor draft law, were to have gone into uniform on or before March 1. But present plans are to order none to duty before May 15. Army medical personnel officials say the postponement will inconvenience few or none and probably will benefit a good many by permitting them to complete, or nearly complete, residency and other training programs.

FTC Disciplines Health Insurer by 3 to 2 Vote

By a 3 to 2 vote of its members, Federal Trade Commission has ordered North American Accident Insurance Co., Chicago, to eliminate deceptive statements from its advertising of health and accident insurance. Split decision parallels FTC's action of last April when it upheld Federal jurisdiction over health insurance advertising and issued a cease and desist order against American Hospital & Life Insurance Co. of San Antonio.

In latest case, majority held North American culpable of misrepresentation. The two man minority's dissenting opinion was in favor of further hearings and disputed FTC's authority over insurance advertising regardless of State regulations.

FTC hearing examiners have ordered two other health and accident insurers to stop dubious advertising practices. These are not final decisions of the Commission. Companies cited are Mutual Benefit Health & Accident Association—better known as Mutual of Omaha—and Prudence Life Insurance Co. of Chicago.

Hays Takes Charge of Toxicological Center

Dr. Harry W. Hays, associate professor of pharmacology and experimental therapeutics at Wayne

University College of Medicine, assumed duties recently as first director Toxicological Information Center. This is a new project, financed by armed forces and Atomic Energy Commission and under scientific direction of National Research Council.

The center will be a clearing house of toxicological data, classified and unclassified. It will have no research mission. For time being at least, offices will be in NRC Building, 2101 Constitution Avenue.

FDA Changes Labeling of Riboflavin and Niacin

Food and Drug Administration plans to fix new minimum daily requirements for riboflavin and niacin. Former would be reduced from two milligrams to one. For niacin, on which no minimum daily requirement has yet been established, it would be 10 milligrams. Last October the Food and Nutrition Board of National Research Council urged the official establishment of a minimum daily requirement for niacin.

For infants, the m.d.r. for niacin would be 2.5 mg. and 0.5 mg. for riboflavin. For children, the niacin standard would be from 5 to 7.5 mg., and 0.75 mg. in the case of riboflavin.

VA Sets Up Full-Time Research Posts in Hospitals

With the appointment of nine full-time clinical investigators, Veterans Administration is revising its medical research program. Hereafter, according to Dr. J. C. Nunemaker, director of VA education and service in Washington, full-time clinical investigators will be appointed in January and July. Up to now, VA has conducted its research through part-time investigators, who spent the major part of their hours in patient care. Under the new system, each clinical investigator will have research as his primary responsibility and will spend at least three fourths of his working time on it. Each will be advised by "an outstanding representative of his special field of medicine." The remainder of the researcher's time will be spent on patient care and teaching other physicians. Appointments, some from VA staffs and some from outside, will be for periods of one to three years.

Two More Appointments Made by Folsom

The new Under Secretary of Health, Education, and Welfare is John A. Perkins, PH.D., 42 year old

president of the University of Delaware; he succeeds Herold C. Hunt, PH.D., who has returned to Harvard. Dr. Perkins, one of the youngest university presidents when he took over at Delaware in 1950, once served as secretary to the late Senator Vandenburg and was State budget director for Michigan.

Mr. Folsom also has a new assistant who holds both medical and law degrees. He is Dr. Robert H. Hamlin, 33, public health director at Brookline, Massachusetts; instructor in public health law at Harvard School of Public Health, and assistant professor of legal medicine, Harvard Law School. Dr. Hamlin will assist in the development and coordination of departmental policies. With these appointments, all major posts in the Department of Health, Education and Welfare are filled, with the exception of that of chief of the Children's Bureau.

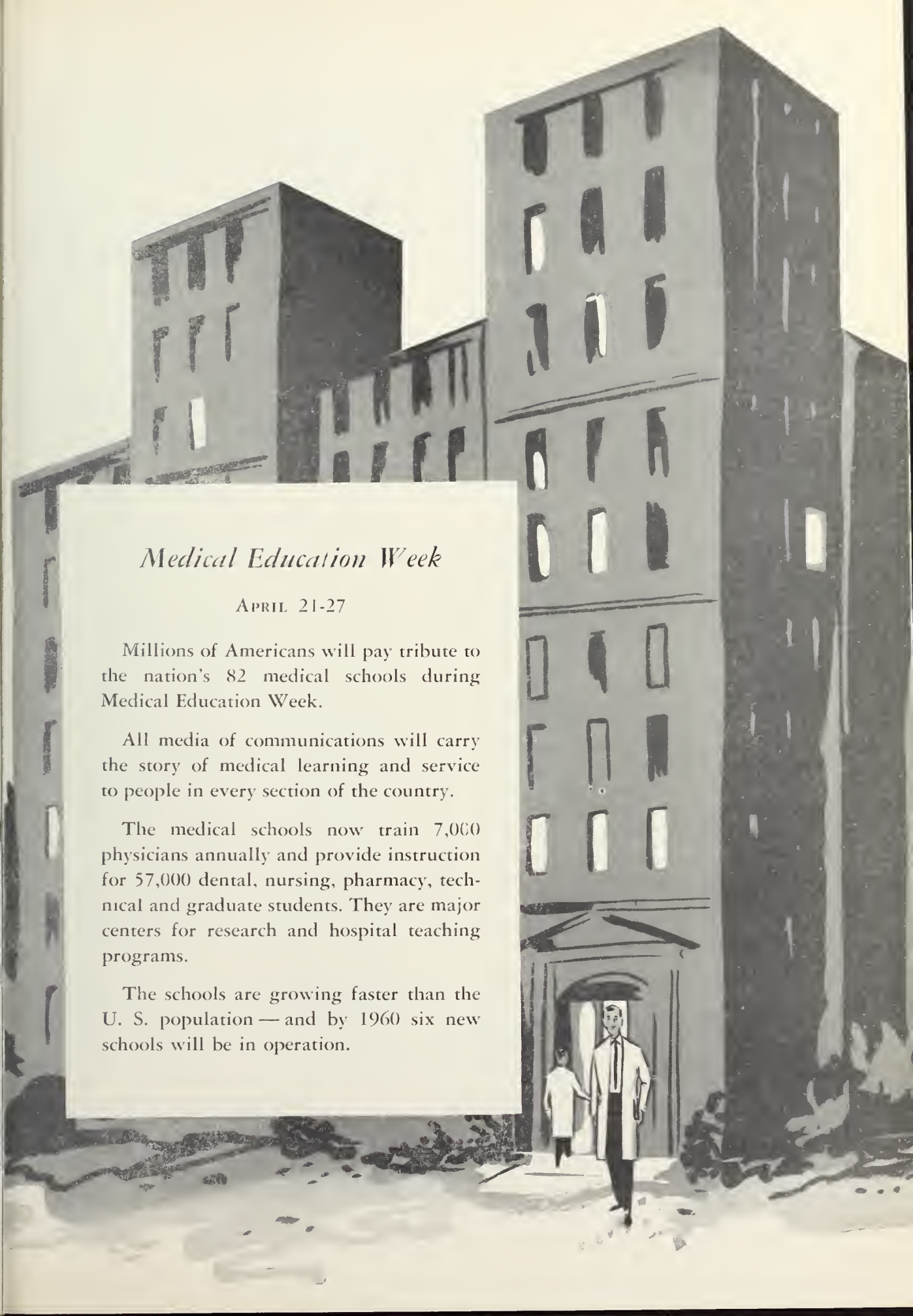
The Need for Broader Coverage

Nearly seven out of ten Americans now carry some form of voluntary health insurance, and insurance is paying a larger proportion of the average person's overall medical bill than ever before. Yet, the full potential of voluntary health insurance has not been reached.

Health insurance today, as underwritten by Blue Cross, Blue Shield and insurance companies, spreads the risk of high costs primarily for hospital care and in-hospital physicians' services—the costs long considered the most difficult for the average family to meet. However, according to the Health Information Foundation study reported in this issue of *Progress in Health Services*, some families run up costs for medical services outside of hospitals (physicians' home and office calls, drugs, dental services, etc.) that frequently exceed the costs of in-hospital services when totaled over a year.

Such high out-of-hospital costs are as unpredictable for the individual family as are in-hospital expenses. According to the Foundation survey, six per cent of the interviewed families incurred charges of more than \$200 for physicians' services outside the hospital during the survey year, while only three per cent incurred more than \$200 in charges for surgical care. In fact, physicians' out-of-hospital charges exceeded \$200 for as many families as did hospital charges. Four per cent of the families spent more than \$200 a year for dental care, two per cent

(Continued on page 376)



Medical Education Week

APRIL 21-27

Millions of Americans will pay tribute to the nation's 82 medical schools during Medical Education Week.

All media of communications will carry the story of medical learning and service to people in every section of the country.

The medical schools now train 7,000 physicians annually and provide instruction for 57,000 dental, nursing, pharmacy, technical and graduate students. They are major centers for research and hospital teaching programs.

The schools are growing faster than the U. S. population — and by 1960 six new schools will be in operation.

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman

Harold A. Bergendahl, Norwich
James C. Canniff, Torrington

D. Olan Meeker, Riverside
Harry C. Knight, Middletown
Stewart P. Seigle, Hartford

James F. Jones, Danielson
James H. Root, Jr., Waterbury
William A. Richardson, Noroton
Associate Member

Emergency Plans Receive 2,700 Calls

More than 2,700 emergency calls were answered during 1956 by eight medical association emergency call plans in various sections of the State.

This is disclosed in the first returns of a survey to study the operating features of the eight emergency plans which have been established by county and local medical associations in major population centers.

The eight plans which have already reported are located in Hartford, Middletown, Willimantic, Bristol, Waterbury and Bridgeport.

The plan which operates in Hartford recorded the largest number of calls, 1,500, while the smallest number was received by the Willimantic plan where 24 calls were answered.

The number of callers who reported they did not have a family physician ranged from none to 50 per cent of the calls received. All eight plans reported that their service is available 24 hours daily through Sundays and holidays. Six of the plans stated their operations are conducted through a commercial switchboard while two plans reported combined use of commercial and hospital switchboards.

Because of completion of dial telephone service in all of the areas, the communities where the plans are located as well as neighboring communities have access to the services without toll charges, it was reported.

Medical Education Week

Medical Education Week, April 21-27, has been accepted as a public service project by the Advertising Council and will be mentioned on many national television and radio programs.

Magazines and newspapers as well as many organization publications also will carry information now being prepared to more completely inform people about the contributions of medical education to American living.

In Connecticut and other States, plans are being developed to implement the national educational project.

Planning will include use of newspaper articles and advertising and tie-in announcements with regular radio and television programs in cooperation with local medical associations and community groups.

Committees of the Woman's Auxiliary to the State Medical Society are cooperating with county association committees in the development of local plans for observing the week.

Medical Films Viewed by Student and Adult Groups

More than 1,400 students at the Nathan Hale Junior High School, New Britain, recently viewed the educational film "Your Doctor" portraying the training of physicians and activities of medical associations. Presented under the auspices of the State Medical Society and the American Medical Association the film is one of a series designed to acquaint students and others with aspects of modern medical education and medical practice.

"Your Doctor" was also shown recently to 450 high school students in Waterbury, Seymour and East Hampton. Two other films, "Operation Herbert" and "A Life to Save" were viewed by 400 adults at community meetings in New Haven, New Milford and Bridgeport. The films may be booked by local medical associations for school or community audiences through the State Medical Society. There is no charge except return postage.

Two New Scientific Exhibits for June AMA Meeting in New York

Two new scientific exhibits for physicians will be on display at the 106th Annual Meeting of the American Medical Association, June 3-7 in New York City.

The exhibits were prepared jointly by the AMA's Bureau of Exhibits, the Bureau of Health Education and the Council on Foods and Nutrition. One of the new exhibits, "Health Appraisal of the School Child," presents the factors involved in complete appraisal, including teacher observation, screening procedures and dental and medical examinations. Each of the major phases is presented in a series of colored slides.

"Food in Oral Electrolyte Therapy," the second exhibit, has been designed primarily for physicians in general practice who may be concerned with electrolyte therapy in the nonhospitalized patient. The exhibit is divided into three major categories: (a) common clinical conditions causing deviation from normal, (b) exhibits of foods useful for replacement therapy and (c) advantages of oral illustration of these elements.

President's Committee for Traffic Safety Initiates Action Program

The President's Committee for Traffic Safety has initiated a national program to furnish community groups with films and other educational aids aimed at reducing travel accidents. Known as the President's Highway Safety Action Program, the plan is based on recommendations adopted by the delegates from 48 States at the Highway Safety Conference held in Washington last year. The program urges community and State action through laws and ordinances, education, law enforcement, motor vehicle administration, highway engineering, accident record studies, and public information and support.

Information concerning the cost of films and availability of printed material may be obtained by writing to the President's Committee for Traffic Safety, General Services Building, Washington 25, D. C.

OUR MEDICAL WORLD

Federal Hospital Insurance in Canada

According to the *New York Times*, the Canadian Federal Government and the Province of Ontario have reached an agreement on the essential terms

for a hospital insurance plan that will eventually cover most of Canada. With Ontario becoming a party to the agreement it would appear that all of Canada may expect the plan to be in operation by 1959.

Under the proposal all hospital bills and most diagnostic and radiological bills will be covered by the joint Federal-provincial hospital insurance plan. The Federal government has promised to pay roughly half the cost of the insurance without increasing taxation. The provinces, however, are free to raise additional revenue to cover their share of the cost in any way they see fit.

Repository for Medical Certificates — a New Service Project of World Medical Association

Because of the tragic losses of educational records and official credentials of physicians resulting from wars and natural disasters in the past, the 10th General Assembly of WMA adopted a recommendation of its Council, approving establishment of a Central Repository for Medical Records.

This action followed an extended study and consultation with other international organizations, none of which proposed to develop such a project themselves. All agreed it was urgently desirable and pledged their support and cooperation to W.M.A. in developing the plan.

The national medical association in each country is to act as the "receiving agent" for the records of the doctors in that country, to verify such records, and to forward them to the W.M.A. Secretariat for deposit. The types of credentials to be legally recognized and eligible for deposit have been established, as well as a system of identification. A repository has been selected. Identification forms and detailed information will be furnished individual physicians through their national medical societies and their component units in the near future.

The Central Repository Project has been developed in accordance with one of W.M.A.'s chief objectives: "to protect the interests of the medical profession." The success of the enterprise will depend on the cooperation of the national medical associations, and ultimately on the participation of the individual doctor whose vital interests this undertaking is intended to protect.

Committee to Study Maternal Mortality and Morbidity

SUBCOMMITTEE ON TOXEMIA

Hugh K. Miller, M.D., Stamford, *Chairman*

Antepartum Toxemia Routine

- I. Activity.
 - a. Single bedroom if possible and no visitors.
 - b. Complete bed rest.
- II. Weight.
 - a. Weigh patient on admission and daily.
- III. Fluids.
 - a. Record intake and output.
- IV. Diet.
 - a. Salt free, high protein diet.
- V. Blood pressure.
 - a. Blood pressure, temperature, pulse, respirations, and fetal heart every four hours.
- VI. Urine.
 - a. Catheterized urine on admission for routine analysis and culture; daily clean urine thereafter for routine analysis.
- VII. Blood chemistries.
 - a. Draw blood on admission for NPN, uric acid, total serum protein, CO₂ combining power, and blood sugar.
 - b. Daily uric acid.
- VIII. Blood.
 - a. Hematocrit, hemoglobin, type and cross-match on admission.
- IX. Medication.
 - a. Sedation.
- X. Consultation.
 - a. Consultation should be obtained.

IMPORTANT

It must be clearly understood that no routine will cover all pre-eclamptic patients. The above routine is merely intended as a guide. It will be modified for the patient who is responding satisfactorily, and will be changed somewhat for the patient that is not improving, and of course must be modified drastically for the patient who is a severe toxemia with imminent convulsions or has already convulsed. It is most important, (a) that the toxic

patient both before and after delivery be watched carefully even though she may appear to be improving (her condition may change quickly); (b) that a competent consultant be called.

Postpartum Toxemia Routine

It is assumed that there are routine postpartum orders in each hospital licensed by the Connecticut State Department of Health to take care of obstetrical patients.

Treatment of the postpartum toxic patient cannot be made a routine except in principle. The first forty eight hours postpartum, and particularly the first eight hours, are the most critical.

It must be remembered that in the care of postpartum toxemia, pre-eclampsia or eclampsia that (1) it may develop for the first time postpartum, (2) pre-eclampsia may be made more severe by labor or may progress into eclampsia. With this in mind the following recommendations are made:

- I. Urine.
 - a. Test catheterized urine taken at time of delivery for albumin immediately.
 - b. Examine subsequent urines for albumin daily if signs of toxemia persist.
 - c. Obtain catheterized urine on the third day postpartum for urinalysis and culture (in order to detect pyelonephritis).
- II. Blood pressure.

Take and record blood pressure.

 - a. Immediately following delivery.
 - b. Then every half hour for two hours.
 - c. Then every one to two hours for six hours.
 - d. Then q.i.d. until discharge.
- III. Medication.
 - a. Continue medication postpartum under consultant's orders.
- IV. Activity.
 - a. Continue with complete bed rest until patient is ordered up by physician.

- V. Intake and output.
 - A. Record intake and output until discontinued by physician.
- VI. Blood chemistries.
 - A. Repeat NPN on third day postpartum (in order to detect renal damage).
 - B. Repeat uric acid third day postpartum (in order to determine progress of toxemia).
 - C. Order additional blood chemistries as indicated.
- VII. Diet.
 - A. Continue low sodium (approximately 500 mgms.) diet postpartum until signs of toxemia have disappeared.
- VIII. Hospitalization.
 - A. Extend usual hospital stay.

LETTERS TO THE EDITOR

The American Medical Society
Vienna, Austria

Vienna, February 7, 1957

To the Editor:

On December 22, the *Journal of the AMA* published two appeals which were written by me, on and for the behalf of the Refugee Hungarian Physicians in Austria.

When I wrote these letters on November 26 and 30, 218 Refugee Doctors had registered with us. As of today's date, there are 680.

Several U. S. physicians have written to me, inquiring as to the success of these appeals. I have informed them that the results were rather disappointing.

I received a letter from an American colleague, who writes and I quote:

"I am very much impressed with the work that you are doing for our colleagues and I wish I could help you more. I thought maybe two suggestions could be helpful in receiving more contributions from the doctors here in the U. S. A. Number one:

I think that if it would be possible to send a short mimeographed letter to the secretaries of all County Medical Societies with a request that they should read the letter to the members of the Society at their next meeting and asking a contribution of only \$1—Nobody would refuse, and many would give much more. This certainly would bring in a large amount of money and maybe the distribution of these letters could be done by each State Medical Society so that your office would have to send these letters to 48 societies only and the rest could be done by the State Societies. I feel that this approach would be more successful than the approach though the journal for the reason that very few read your letter in the journal. As a matter of fact, in my community there are thirty doctors and nobody saw this letter. My second suggestion would be to get in touch with the Commissioners of Mental Health in each of the States and ask them about the possibilities of employing Hungarian Refugee doctors in mental hospitals. The need is great and to my knowledge they were very satisfied with services they received from Hungarian Refugee doctors up until now. I, myself, was working for seven months in a mental hospital." (Name on request.)

We would be most grateful to you, if you could publish my appeals in your JOURNAL, and call the attention of your local and regional Medical Societies to the fact that over 680 Hungarian Refugee doctors have, and most of them are still, receiving our aid.

Although the immediate urgency of the situation has been alleviated, there are presently over 450 Hungarian doctors in Austria who wish to return to their practice as soon as a change in the Hungarian political situation permits. In fact we are urging these colleagues to remain here attending this possibility, for we feel that most of them, should they emigrate to the U. S. A., will encounter considerable difficulty with language and "State Board" requirements. To maintain them here, will require our further support for several months to come.

Your cooperation in this matter would be gratefully appreciated.

Sincerely,
M. Arthur Kline, M.D.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. E. Roland Hill, Mystic

President-Elect, Mrs. Paul W. Tisher, New Britain

First Vice-President, Mrs. Edwin R. Connors, Bridgeport

Second Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Corresponding Secretary, Mrs. Saul Karpel, New London

Recording Secretary, Mrs. Norman H. Gardner,
East Hampton

Treasurer, Mrs. J. Alfred Wilson, Meriden

President, Mrs. E. Roland Hill

Annual Meeting

The Annual Meeting of the Woman's Auxiliary to the Connecticut State Medical Society will be held May 1, 1957, 10:30 A. M. at the Hartford Golf Club, West Hartford. Mrs. Luther H. Kice, parliamentarian and past national president of the Woman's Auxiliary to the AMA, will be the National representative. Mr. Thomas Hendricks, field representative of the AMA, will be the guest speaker following the luncheon at 1:00 P. M. Mary Langdon, contralto, will be guest soloist. Her accompanist will be William Dale. Following the meeting there will be a reception and tea honoring the past presidents at the home of Dr. and Mrs. John D. O'Connell, 42 Fulton Place, West Hartford. An invitation had been extended to all members to attend the Annual Dinner of the Connecticut State Medical Society.

Dr. and Mrs. Norman Gardner, East Hampton, attended the AMA Rural Health Meeting in Louisville, Kentucky, March 7, 8, 9. Dr. Gardner is a member of the National Rural Health Committee of AMA.

Mrs. Dewey Katz, Public Relations chairman, called a meeting of her committee in New Haven at the Connecticut State Medical Society Building, March 5, at 1:30 P. M.

Board of Directors Meeting

The final meeting of the Board of Directors this year was held February 25 at the Connecticut State Medical Society Building with almost 100 per cent attendance.

Mrs. Edwin Connors, Membership chairman, reported: total membership 1,193, 82 new members, 24 resignations, and 67 dropped for nonpayment of dues.

Letters and a copy of *The Quarterly* were sent to each eligible member in Tolland County.

Mrs. Royal Meyers, *Today's Health* chairman,

reported a total of 1036½ credits. With a little additional effort our State quota should be met this year.

Following County Reports were given:

NEW HAVEN

Mrs. Wakeman reported 176 paid members, 12 of whom are new and one reinstated. March 11, a Membership Meeting was held at Yankee Silversmith at which time the Constitution and By-Laws were revised. An invitation was extended to the Meriden Auxiliary to join the group for luncheon to hear Mrs. E. Roland Hill, the State president. A musical program followed by a string trio of the Yale Music School.

NEW LONDON—Mrs. Rasmussen

AMEF Dinner Dance held at Lighthouse Inn with 175 reservations netted \$254. Dr. and Mrs. E. Roland Hill were guests for the evening. In December a Membership Tea was held at home of Mrs. Richard Starr with 55 present. Several members have become volunteer workers at Norwich State Hospital.

HARTFORD—Mrs. O'Connell

Membership 515. The Woman's Auxiliary realized a profit of \$530 for Memorial Scholarship Fund from 3rd Annual Medi-Capers Dance. The Memorial Scholarship Fund has received \$1,190 from letters sent to Auxiliary members in November. Donations were sent by members in memory of physicians or auxiliary members of Hartford County who had died during the previous year. Thirteen scholarships were granted this year and \$485 sent to AMEF. Annual Meeting was April 2 at Carriage House in Simsbury with Professor Albert E. Burke, speaker.

MIDDLESEX—Mrs. Soreff

Membership of 68 with two new members. AMEF chairman reported \$135 collected to date and she hopes to encourage the use of AMEF Memorials to add to funds. Ten dollars allotted for toy closet in Children's Ward at Middlesex Memorial Hospital. Mental Health Meeting, March 12, with Dr. Paul Graffagnino as speaker. Annual Meeting April 25.

FAIRFIELD—Mrs. Nespor

Membership 238. Board voted \$300 for AMEF this year. Record player and four records given to Fairfield State Hospital, also over a hundred gifts at Christmas time to Laurel Heights Sanitarium. Nurse Scholarship Fund raised to \$400 this year. A Gems Class started in Westport recently. Annual Meeting April 9.

WINDHAM—Mrs. Woodworth

Dessert Bridge held at Nathan Hale Hotel in Willimantic to raise money for AMEF. During the month of March the Nurse Recruitment Project was carried out, which was to transport girls interested in becoming nurses from the various high schools in the county to local hospitals for a tour, talk by officials and students, and an informal tea.

Today's Health chairman reports 113 per cent quota in contest to date.

1955 Distribution of Hospital Beds

New England and the Middle Atlantic States provided more psychiatric beds per 1,000 population than any other section of the United States in 1955. In these two sections also more beds were allocated for psychiatric diseases than for any other types. The New England States the same year had fewer governmental (nonfederal) hospitals than were found in any other section.

Connecticut in 1955 had at least 4.80 beds in general hospitals per 1,000 population, and at least 5.50 beds in psychiatric hospitals per 1,000 population. The New England States had a 73 per cent average bed occupancy in nonfederal, short-term general and special hospitals. This was one per cent above the national average rate.

Mr. George Bugbee, president of Health Information Foundation, in a recent editorial comments as follows:

"There are still many American communities with too few hospital beds and some without hospital facilities. Moreover, even communities matching the national bed-population ratio of 4.2 beds per 1,000 are not exempt from the continual self evaluation of bed needs.

"If anything, this difficult self evaluation is becoming increasingly complex. With a growing population; a larger group of people in the upper age grades who require more days of hospital care per year; an increased use of hospitals by physicians

in providing modern medical care to persons of all ages and a concomitant decrease in the duration of many acute illnesses, to mention only a few factors, there is cause for thoughtful planning ahead in all of our hospitals."

Live Poliomyelitis Vaccines

The British Medical Journal (5010, January 12, 1957) contains two reports of trials with live virus vaccine for poliomyelitis by workers at Queen's University, Belfast, Ireland. The first report deals with the results obtained from a trial of TN type II vaccine in which 21 adults, 10 infants, and 159 children were fed this attenuated poliovirus vaccine. No significant illness was observed in any individual during the month following vaccination. Twenty two per cent of the adults and 77 per cent of a group of children developed type II antibody in response to vaccination. The development of antibody in children and in infants was associated with the excretion of the virus. The laboratory characteristics of attenuation shown by TN type II virus which made it appear suitable for trial as a vaccine were found not to be maintained after multiplication in human gut.

The second report by the same group deals with a trial of SM type I attenuated poliomyelitis virus vaccine. Here only eleven adults, two infants, and one child were fed the vaccine. None of the 16 developed any serious illness. All these subjects were without type I antibody at the time of vaccination and all developed antibody after vaccination. All became fecal carriers of virus, the duration varying from one to more than seven weeks. This virus was considered suitable for trial as a vaccine because it did not cause paralysis in monkeys when inoculated by the intracerebral route. However, the virus underwent a change after multiplication in the human gut, and SM fecal virus, unlike the vaccine virus, caused paralysis in a proportion of monkeys inoculated by this route. In addition it was found that SM virus can spread from the vaccinated to the unvaccinated.

In an editorial comment it is pointed out that "the most important aspect of this work is concerned with the altered character and behaviour of the excreted virus." This work points out the need for safety requirements in the use of attenuated virus vaccines. As the editor points out: "In developing new strains for use in this way more attention will clearly have to be paid to the problem of transmissibility and to the character of faecal virus."

OBITUARIES

William M. Stahl, Sr., M.D. 1890 - 1956



Dr. William Martin Stahl, of 343 Main Street, Danbury, died on December 11, 1956. He was in his 66th year.

After receiving his degree in medicine in 1914 from the University of Maryland and serving a rotating internship at the University Hospital, Baltimore, Maryland from 1914 to 1915, Bill Stahl returned to Danbury, his home town, to begin the practice of medicine. Like most medical men of that era he elected to start as a general practitioner, since he believed that was a logical stepping stone to his real love, general surgery. His fine training and his engaging personality very soon assured him of a thriving and highly successful practice. This practice was temporarily interrupted from 1917 to 1919 when he served in the medical corps both in this country and abroad during World War I.

After his return from military service he acted as surgical assistant to Professor Arthur Shipley at the University Hospital, Baltimore from 1920 to 1921. This together with his army experiences equipped him still more for his future career as a surgeon, so that not long after resuming his civilian practice he found that surgery was demanding so

large a part of his time that in his later years he limited his practice to that specialty.

Bill maintained a summer home in Searsport, Maine, and he was never happier than when spending his vacation days in that delightful seaport town either on his boat or trying to break par on a nearby golf course.

Organized medicine never failed to receive Bill's support and his keen interest was rewarded by his election to the presidency of the Fairfield County Medical Association and to the chairmanship of the staff of the Danbury Hospital. At the time of his death, besides being a member of the national, State, and local medical associations, he was a Fellow of the American College of Surgeons, a Fellow of the International College of Surgeons, and a member of the American Gastroenterological Association. He was consulting surgeon at the Danbury Hospital and the New Milford Hospital and was a surgeon at the Fairfield State Hospital.

He is survived by his wife, Isabel W. Stahl, and by three children, Mrs. Bette J. Schoen, Dr. William M. Stahl, Jr., and Frederick A. Stahl.

Dr. Stahl was extremely devoted to his profession, and he had the love and respect of his patients and friends and of those who worked with him. We shall all miss him.

John D. Booth, M.D.

Frank J. McGuire, M.D. 1910 - 1956

Dr. Frank J. McGuire died at his home in Guilford on September 1, 1956 at the age of 46. He had been in ill health for two years with osteogenic sarcoma which necessitated the removal of his right leg and right lung.

Frank was born in New Haven on April 24, 1910, the son of the late Dr. and Mrs. Frank McGuire. His father graduated from Yale Medical School in 1897. Frank received his Bachelor's degree from Yale in 1932 and his M.D. from Boston University School of Medicine in 1937. He interned for two and one half years at both the Binghamton City Hospital in Binghamton, New York and at the

Massachusetts Memorial Hospital in Boston. A short time later he began to practice in Guilford.

Frank served overseas in the South Pacific as a flight surgeon with the Air Force from November 1942 until October 1945. He was wounded in 1943 but continued in active service.

Following the war he resumed general practice in Guilford. He was on the staff of the Hospital of St. Raphael and was a member of the New Haven, the New Haven County, the Connecticut State Medical Societies and the American Medical Association. He served as medical examiner for Guilford.

He is survived by his wife, the former Norma Redner of Binghamton, New York, and one son, Frank, Jr., a student at the Loomis Preparatory School.

Frank was an accomplished musician with a very keen sense of humor and took part in many community activities. He was an exceptionally kind, capable and sympathetic physician and will be sorely missed by the people of Guilford. I have lost a very close friend.

Lawrence M. Tierney, M.D.

Philip G. McLellan, M.D.

1900 - 1957



Dr. Philip Garretson McLellan died very unexpectedly at his home in West Hartford in the early evening of January 22, 1957. He was in unusually

good spirits the day of his death and performed an emergency appendectomy just before he went home for the day. Dr. McLellan is survived by his wife and two children in West Hartford, and a brother in California.

Dr. McLellan was born in Caribou, Maine, February 28, 1900. After graduating from the Caribou High School he earned an A.B. degree at Bowdoin College where he was a member of Delta Kappa Epsilon Fraternity. He then entered Harvard Medical School, graduating in 1925. Phil was always a good student and made a good record as well as many friends. In medical school he was a member of Alpha Kappa Kappa Fraternity.

After working in the laboratory of Hartford Hospital as a student he began his internship there in February of 1926. After the completion of this appointment he became resident in surgery at the Union Memorial Hospital, Baltimore, Maryland.

Dr. McLellan returned to the Hartford Hospital in 1931 and was appointed assistant surgeon in June of that year. During the next few years he helped in the development of thoracic surgery at the Hartford Hospital and devoted many hours to the establishment of the Breast Follow-Up Clinic. He became a member of the Hartford Medical Society, Hartford County and Connecticut State Medical Societies, as well as a Fellow of the American Medical Association and the American College of Surgeons. At the inception of the American Board of Surgery he became a Diplomate, and also became a member of the New England Cancer Society and the New England Surgical Society. When the Connecticut Society of American Board Surgeons was founded he was a charter member.

In 1942 Dr. McLellan volunteered his service as a Lieutenant Commander in the USNR. He served in hospitals in this country and later with the Fifth Amphibious Corps, attached to the United States Marine Corps on Iwo Jima and in Japan, sharing in the Unit Citation awarded the Corps on Iwo Jima. He was discharged from the service in December, 1945 with the rank of Commander (MC)—USNR.

In 1947 Dr. McLellan became visiting surgeon at the Hartford Hospital. He served on many committees and demonstrated unusual organizational ability. Through his work on the Graduate Medicine Committee and the Executive Committee of the Staff great benefits have been derived by the

hospital. He has served as chairman of the Executive Committee of the staff and in 1956 was president of the Medical and Surgical Staff. At the time of his death he was director of the Department of Surgery, devoting much time to the surgical training program and the many facets of hospital organization associated with that position.

Outside of his professional activities Dr. McLellan found relaxation and pleasure in raising flowers. He was interested in cross breeding of iris and was a member of the American Iris Society and the American Rose Society.

Phil will be missed by the community, his many friends and patients.

Ralph T. Ogden, M.D.

William Weiner, M.D.

1913 - 1956



Dr. William Weiner, Danbury, died suddenly and unexpectedly on December 4, 1956, two hours after admission to the Danbury Hospital. He had suffered a severe heart attack in May of the same year and had recovered very well. We had hoped to have him with us for many years to come but it was not to be.

Dr. Weiner was born in Boston, Massachusetts on March 7, 1913, the son of the late Herman Weiner and Mrs. Francis Weiner. He received his B.S. at Tufts College in 1934 and his M.D. at Tufts College Medical School in 1938. Following his

graduation from medical school he interned at the Danbury Hospital, 1938-39; St. Francis Hospital, in Hartford 1939-40; and served a residency at Michael Reese Hospital in Chicago, 1940-42. His license to practice medicine in Connecticut was issued 1942. In 1946 he joined the department of anesthesiology of the Danbury Hospital, later became its chief and organized it into its present state of high efficiency. He was certified by the American Board of Anesthesiology in 1951.

In addition to his position as chief of anesthesiology at the Danbury Hospital, he was consultant at the New Milford, Fairfield State, and Mahopac Hospitals. He was a member of the American Society of Anesthesiology, the International Anesthesia Research Society, the Fairfield County and Connecticut State Medical Societies.

Surviving him are his mother, his wife, Mrs. Marcia Smith Weiner, and two children, Harriet and Peter.

Bill Weiner was an extremely honest and sincere individual. In his field of medicine he was outstanding. We shall miss him.

Frank M. Goldys, M.D.

NEED FOR BROADER COVERAGE

(Continued from page 366)

more than \$200 for medicines. While only a relatively few families incur extra large medical expenses of any type during the year, there is a strong chance that, if heavy expenses do occur, they will involve out-of-hospital treatment rather than (or in addition to) in-hospital treatment.

It is not necessary to look far for examples. Some parents with young children, faced by sizable expenditures for pediatric care, dental care and drugs, must make sweeping revisions in the family economy. The prospect of such expenditures undoubtedly makes some parents put off getting necessary medical care for their children or themselves. And we need scarcely mention the risks of chronic disease, needed medical care for the elderly and items such as prosthetic devices. In the aggregate, they can seriously upset almost any family budget.

Is it the responsibility of voluntary health insurance, then, to cover all these health expenses? No, and it may not be economically feasible or philo-

(Continued on page 392)

AROUND THE STATE

CMS Eighth Annual Meeting Announces New Coverage

Three new Endorsements and a new Rider for CMS members were announced at the eighth annual meeting of Connecticut's plan for the prepayment of surgical-medical care. Thomas J. Danaher, M.D., president of CMS, announced that the supplemental coverage will be available in the very near future to CMS firms having the Preferred Contract coverage. Three Endorsements to add Indemnity coverage at 25 per cent, 50 per cent and 100 per cent of the Preferred Contract benefits will be made available through CMS participating firms for people whose annual incomes are above the Service Benefit (full payment) level. The Executive Endorsement (100 per cent) will double the benefits to increase the section limits of the Preferred Contract from \$300 to \$600 annually, while the annual benefit limit of \$1,800 is increased to \$3,600.

In addition a new Rider will be available to provide coverage for the first three days of Inhospital Medical Care at the rate of \$15 for the first day, \$10 for the second day and \$5 for the third day. This Rider will be available to all CMS Preferred payroll groups on a 100 per cent participation basis. The additional coverage is being made available in conjunction with the aim of CMS to provide the best possible coverage at all times at the lowest possible cost. The need for this additional coverage is substantiated by the overwhelming acceptance of the conversion to the Preferred Contract in 1956. At the present time 97 per cent of CMS Membership is now on the basis of the Preferred Contract.

Robert S. Judd of Hamden, who had served as president of CMS since it was founded by the State Medical Society, was re-elected to his second term as chairman of the CMS Board of Directors. Thomas J. Danaher, M.D., Torrington, was also re-elected to his second term as president of the statewide Blue Shield Plan. J. Edison Doolittle, Milford, vice president and comptroller of the Southern New England Telephone Company, was re-elected to his second term as CMS vice president, and Louis F. Middlebrook, M.D. of West Hartford and Carl G. Freese of Hamden were re-elected as CMS secretary

and treasurer, respectively. Henry A. Archambault, M.D. of Taftville was re-appointed to his second term as chairman of the CMS Professional Policy Committee.

Referring to other highlights of CMS operations Dr. Horton emphasized the acceptance of the Preferred Contract by over 97 per cent of CMS members and the continued high return of members' dollars in the form of benefits. He stated that 87¢ of every dollar received was returned in current benefits and that an additional 2.7¢ of each dollar was returned for members' future benefits.

Claim payments by CMS were reported by Dr. Horton to have been accepted as full payment for services rendered in 67 per cent of the 211,806 cases paid during the year, representing an increase over 1955 and including 14 per cent where the members were over the income limits for Service Benefits but where the doctors charged no more than the CMS payment. Dr. Horton commented that this outstanding record more than substantiates the unprecedented contribution by the Participating Physicians to the surgical-medical welfare of the people of Connecticut.

Re-elected to one year terms on the Board in addition to the officers named above, were: Dr. Archambault, Creighton Barker, M.D. of Hamden; John Coolidge of Farmington; William Gumbart of Hamden; Thomas P. Murdock, M.D. of Meriden; Walter I. Russell, M.D. of New Haven.

New appointees nominated by the Council of the Connecticut State Medical Society are Edwin R. Connors, M.D. of Bridgeport and Edward Howe, M.D. of Hartford. Appointed after their election by 2,761 CMS Participating Physicians were John D. Booth, M.D. of Danbury; Philip M. Cornwall, M.D. of Hartford; and Amos E. Friend, M.D. of Manchester.

Other physicians serving on the Professional Policy Committee are Orpheus J. Bizzozero of Waterbury; Robert G. Reynolds of West Hartford; Allan J. Ryan of Meriden; and Harold E. Speight of Middletown.

Ralph T. Ogden of West Hartford, president of the Connecticut State Medical Society, and W.

Bradford Walker of Cornwall, president-elect of the Society, serve on the Committee by virtue of their offices.

Poliomyelitis in Connecticut

Hila E. Rindge, epidemiologist of the State Department of Health, reports on 79 cases of poliomyelitis in pregnancy in Connecticut in the *New England Journal of Medicine*, February 14, 1957. The report covers a period from 1951 to 1955 and points to the fact that it is now generally accepted by most authors that the risk of poliomyelitis in the pregnant woman is greater than that in the non-pregnant. The danger of contracting poliomyelitis apparently is greatest in the second trimester of pregnancy, the danger of fetal loss in the first trimester, and the danger of maternal mortality in the third trimester. The incidence of paralysis among the pregnant women with poliomyelitis was slightly higher than that among other cases of poliomyelitis reported in this five year period.

Connecticut figures lend support to the theory that there is a tendency for poliomyelitis to occur in the first trimester of pregnancy in women who are carrying a male fetus and in the third trimester in those carrying a female fetus, as well as to the theory that some factor related to household contact with children or associated with the presence of children in the household may account for the increase of poliomyelitis observed in pregnant women.

The observation that poliomyelitis in pregnancy, particularly in the early months of the pregnancy, may lead to a general retardation of development of the infant is again made.

This short contribution by Dr. Rindge is of particular value in pointing out the fact that the incidence of poliomyelitis in pregnancy is on the increase. The disease is rapidly losing its prevalence among infants and is becoming a disease of young adults.

Connecticut Regional Blood Program

The New Haven fire brought to the Connecticut Blood Program the thought of evaluating its preparedness for disaster even though this incident had not taxed its facilities. Fifty minutes after the call from New Haven, 48 pints of universal whole blood and 32 units of plasma and of serum albumin were delivered by the State Police.

The evaluation pointed out the following: (a) there are at all times about 2,500 pints of typed blood in hospitals; (b) there is always a disaster supply of 48 pints of O-negative blood and 50 units of albumin at the Center in Hartford; (c) within a few hours Centers in nearby States could send in blood and plasma; (d) other hospitals in the State would quickly supplement the existing emergency supply.

In a prolonged situation, all three Center mobile units would be worked to capacity. The Red Cross in Connecticut has a complete file by type of all donors to the program and consequently it would not prove difficult to get donors by type in any quantity needed.

Disasters are infrequent, but because of Connecticut's Blood Program its residents can rest assured that their blood needs will be met in any emergency.

	JULY 1, 1956 THROUGH FEBRUARY 28,	
DONORS	1957	1957
Donors accepted	6,569	57,163
Donors rejected	714	6,137
Donors registered	7,283	63,300
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from center	5,644	48,839
Blood collected by hospitals.....	755	5,545
To fractionation stock pile.....	142	529
To out of state hospitals.....	83	732
	6,624	55,645
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	94	787
Processed into packed cells.....	2	53
Processed into liquid plasma.....	352	6,703
	448	7,543
Discarded — unfit and broken.....	30	447
Grand Total — distribution of blood...	7,102	63,635
Blood returned to center for processing into plasma and fractions.....	335	5,886
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	83	419
Fresh frozen plasma (125 cc.).....	199	1,502
Serum albumin (100 cc.).....	93	1,415
Packed red cells (bottles).....	2	53
Fibrinogen (bottles)	0	8

Fairfield County

The Griffin Hospital in Derby has been approved for the first time in its history by the AMA Council

on Medical Education and Hospital for an intern training program. Six rotating internships have been allocated to this hospital.

Louis J. Fincke of Stamford has been reappointed by Governor Ribicoff to the State Board of Medical Examiners.

Joseph J. Esposito of Bridgeport has been appointed by Governor Ribicoff to the Advisory Committee to the Coordinator of Atomic Development Activities for the State of Connecticut.

Hartford County

T. Stewart Hamilton, director of the Hartford Hospital, received an award in the form of a certificate presented to him during his recent visit in Mexico City where he participated in a seminar on hospital administration. The certificate was presented by the American Hospital Association together with several Latin-American institutions and was printed in Spanish.

Francis J. Braceland, psychiatrist-in-chief at the Institute of Living, Hartford, delivered one of the keynote addresses at the recent National Health Forum held in Cincinnati, Ohio. Dr. Braceland's subject was "Putting Available Tools to Work to Improve Mental Health." He served as chairman of the 1957 Forum Committee.

Peter V. Stoughton, son of the late Dr. Dwight H. Stoughton and at present a resident at the Hartford Hospital, has been named the first recipient of the newly established Inez M. Gwynne Research Fellowship. The purpose of the Fellowship is the further development of research in the cardio-respiratory field and assistance to a physician interested in this specialty. The Fellowship carries a stipend of \$5,000 annually for not more than three years and was made possible by a bequest in the will of Mrs. Inez M. Gwynne of West Hartford.

Cyril Sanger, Fellow of the Faculty of Anaesthetists, Royal College of Surgeons, has begun his service as a Special Fellow in Anesthesiology at the Hartford Hospital.

George A. Crawley of West Hartford has been appointed chief medical officer at the Wethersfield State Prison. He succeeds Foster E. Priddy who has been prison physician for 26 years. Dr. Crawley is regimental surgeon for the 169th Infantry, Connecticut National Guard, with the rank of lieutenant colonel.

The Reverend Donald Harrington, minister of the

Community Church of New York will be guest speaker at the 165th annual meeting of HCMA on Tuesday, April 2 at the Hartford Club. Dr. Harrington will speak on "The Doctor's Role in International Affairs."

New presidents of the New Britain Medical Society, the Bristol Medical Society, the East Hartford Medical Society and the Manchester Medical Society in their respective order are: Henry W. Kraszewski, Armano W. Ciccarelli, John J. Murphy and Charles H. Peckham.

Instructing for the seventh year at the twenty fourth annual meeting of the American Academy of Orthopaedic Surgeons in Chicago was Charles W. Goff. His course was on "Legg-Calve-Perthes and Related Osteochondroses."

The Manchester Medical Society has appointed a seven member committee to study the polio vaccination problem. Robert R. Keeney will head the group. Others are Howard Boyd, Joseph Barry, Nicholas Marzialo, Francis Helfrick, George Lundberg, Jr. and Melvin Horwitz.

One of the speakers at the first 1957 session of the course on the economics and relationships of medical practice sponsored by the State Medical Society and Yale was William H. Horton of Windsor. Dr. Horton is director of Connecticut Medical Service. He discussed the growth of CMS. Also speaking on this same lecture course were T. Stewart Hamilton, director of Hartford Hospital, and Robert A. Goodell, medical director of Phoenix Mutual Life Insurance Company. They discussed the aspects of administrative medicine in connection with medical training and practice.

New diplomate of the American Board of Orthopedic Surgery is Arthur J. Driscoll, Jr. of Bristol. Dr. Driscoll is a graduate of Harvard College and Boston University School of Medicine. He is a member of the Boston Orthopedic Club and is on the hospital staff of the Bristol Hospital, the New Britain General Hospital, and the Newington Home and Hospital for Crippled Children.

Last month Dr. Hilda C. Standish of Hartford addressed the Buckley School PTA (Manchester) on "Sex Education for the Elementary School Child."

Speakers on a panel sponsored by the New Britain Heart Association were John C. White, Joseph L. Kalett and Howard Levine. William J. Lahey of Hartford also participated.

Middlesex County

Norman H. Gardner of East Hampton, a member of the AMA Council on Rural Health, was one of the presiding officers at the 12th National Conference on Rural Health held in Louisville, Kentucky last month.

Sanford Harvey has left his practice in Middletown in order to take a three year residency in physical medicine and rehabilitation, at Grace-New Haven Community Hospital. Carl Harvey is going to cover the practice.

Mark Thumim has moved his office to 57 South Main Street in Middletown where he will continue in the practice of eye, ear, nose and throat diseases.

New Haven County

Luigi Mastroianni of New Haven is coauthor together with John Rock of Boston of "Introital Obstruction to Intronmission" published in *Obstetrics and Gynecology*, January, 1957.

H. M. Marvin, associate clinical professor of medicine at Yale University School of Medicine and literary editor of the *JOURNAL*, spoke at the Hartford Hospital recently on "Unusual Manifestations and Unusual Types of Heart Disease."

UNDERCLIFF HOSPITAL: WHAT IT IS AND DOES

Undercliff, located in Meriden, was for many years a State tuberculosis sanatorium. Two years ago, by Executive Order, it was attached to the State Commission for the Chronically Ill, Aged and Infirm, and last July 1, by another Executive Order, it was separated from the C.I.A.I. and placed under the jurisdiction of the Department of Mental Health.

Undercliff, compared to our State hospitals, is a small institution with some 270 beds. It is an "open" hospital, without the security features of the typical mental hospitals. There was another factor, in addition to the overall needs of the mental health program, which indicated how Undercliff should be put to use. This was a consideration of obtaining optimum benefits from Undercliff's existing staff in the light of its training and experience.

Today this hospital has two types of patients:

It has about 150 senile patients transferred from the three State hospitals on extended visit status. These are patients who can get along in an open ward setting, who are not so confused that they

will wander, who are capable of a good degree of self care, and whose needs are largely for medical and nursing care, occupational and activity therapy.

This type of patient, and those who comprise the second group, are selected on medical grounds by the staff of Undercliff Hospital in collaboration with the staffs of the State hospitals. Their transfer is effected with approval of the patients' relatives.

None of Undercliff's patients are admitted directly from the community, only by transfer from a State hospital.

Never is the older patient who is a candidate for transfer compelled to leave the State hospital for Undercliff. Rather the patient is told about the program and physical setting at Undercliff and the expectation that he would assume a greater responsibility, and an effort is made to convince the patient of the desirability of the change.

If the removal to Undercliff stirs up the patient's psychiatric illness, causing unusual depression or excessive activity, he is returned to the State hospital for further psychiatric treatment. Thus far the rate of return has been less than 10 per cent.

For the second group of patients, men and women like the first, Undercliff is providing a half-way setting. These patients come from the chronic wards of the State hospitals; they are younger persons who have tried to make a go of it in the community and failed. In some instances they have made the effort several times.

Some 65 patients of this type are now at Undercliff and the number will grow to 100 or 110.

In Undercliff's program for this group, efforts are made to strengthen their preparation for community life, with emphasis on occupational therapy, vocational aptitude and capacity testing, training and placement, and resocialization.

It is expected that as the program develops, members of this group will go into the community to work, returning to Undercliff at night. The goal is to erase the need for the patient's dependency on the hospital and achieve his return to the community and a productive life.

THE WATERBURY MEDICAL ASSOCIATION, 1857-1957

The Waterbury Medical Association was founded on February 5, 1857. One hundred years later to the day, on Tuesday, February 5, 1957, 170 members of the Society and their guests from Connecticut, New York and Rhode Island assembled

at the recently renovated Castle Memorial Building, the permanent home of the Society, to begin the year long program of celebrating this historic event with a centennial dinner. William Finkelstein, president of the Society, acting as chairman of the meeting, first welcomed those present and then sketched the historical background of Waterbury and the United States at the time of the founding of the Society. He then presented Edward H. Kirschbaum of Waterbury who gave the Centennial History. After many months of painstaking, meticulous research into the archives of the Society, the local newspapers, many histories, war records and similar documents, Dr. Kirschbaum produced a fascinating story full of well known and little known facts from the first bonesetter of the tiny settlement of Waterbury in the 17th century to the present large active Society of 175 members.

Following this there was a pleasant social hour after which the gathering retired to the upstairs hall which had been tastefully decorated by members of the Women's Auxiliary. Subsequent to brief remarks by Mayor Edward Bergen; Stanley H. Osborn, State health commissioner; Alex Burgess, Sr. of Providence, representing the American College of Physicians; Mr. Frederick Kilgour, librarian of the Yale University School of Medicine; and Dr. Jeanne Audet, president of the Woman's Auxiliary; and an invocation by Reverend Ivey Shuff, president of the Waterbury Ministers' Association, a gourmet's dinner was served.

This was followed by the climax of the celebration, a truly magnificent Centennial Oration by John C. Krantz, Jr., professor of pharmacology at the School of Medicine of the University of Maryland. In his discourse entitled "The Simplicity to Wonder," Dr. Krantz portrayed some of the highlights in the truly inspiring development of medicine, ending with a challenge to the profession of today to meet the problems of the atomic age. The oration was a beautiful illustration of "The Art of Eloquence," a book written by Dr. Krantz in collaboration with the distinguished governor of Maryland, the Honorable Theodore McKeldin. As was most fitting, the oration was greeted with spontaneous prolonged applause, unequalled in the memory of those present.

Dr. Finkelstein brought the evening to a close with the observation that both essays and all material relevant to the staging of the dinner would be preserved as part of the permanent files of the Water-

bury Medical Association, both as a historical record for the Sesquicentennial Celebration to review, and as an achievement to emulate. He also announced some of the other programs to be held as part of the Centennial Observation, including a lecture on "Heart Disease" for the public on the evening of April 24 to be given by Dr. Paul Dudley White; an exhibit at the Castle Memorial Building on September 25, 26, and 27 on "One Hundred Years of Medicine in Waterbury," including a lecture September 26 to be given jointly by the Medical Association and the Mattatuck Historical Association on "Colonial Medicine in Connecticut;" and a lecture December 12 by Mr. Frederick Kilgour on "One Hundred Years of Connecticut Medicine," preceded by a buffet supper for members of the Society and its Auxiliary.

ST. RAPHAEL'S NEW RADIATION CENTER

Connecticut's first complete radiation center was opened at St. Raphael's Hospital in February of this year. Construction of this new radiation therapy center was supported by a generous grant of \$125,000 from The New Haven Foundation with additional funds obtained from the Federal government, the Ford Foundation, and private benefactors. Included in the facilities are the following: a superficial therapy unit; a conventional 250,000 volt x-ray machine; a new 250,000 volt device specially designed for rotational therapy; a complete radium armamentarium for interstitial and intercavitary use; Connecticut's most modern clinical radioactive isotope laboratory; and a giant kilocurie cobalt bomb equivalent to 3,500,000 volts of x-ray.

Included in the center is a modern tumor clinic for the diagnosis and care of patients. A lecture room seating forty people will provide space for teaching purposes.

Yale University School of Medicine

Two papers by members of the faculty of the Yale University School of Medicine presented at the 105th Annual Meeting of the American Medical Association in Chicago in June, 1956 appeared in the *Journal of the American Medical Association*, February 16, 1957. One on "Differential Diagnosis, Pathology, and Treatment of Substernal Goiter" was by Gustaf E. Lindskog, professor of surgery, and Ira S. Goldenberg, instructor in surgery. The other entitled "Intersexuality" was written by John McL. Morris, associate professor of gynecology.

William H. Resnick, associate clinical professor, presided at the Third Annual Symposium on Cardiovascular Diseases held this month at the Connecticut Power Company auditorium in Stamford.

C. Lee Buxton, professor of obstetrics and gynecology, is the author of "Prepared Childbirth and Rooming-In at Yale" which appeared in the February, 1957 issue of the *Pennsylvania Medical Journal*. This paper was presented at the 106th Annual Meeting of the Medical Society of the State of Pennsylvania.

NATIONAL FUND FOR MEDICAL EDUCATION GRANTS TO YALE

In February of this year Yale University School of Medicine received \$35,930 in grants from the National Fund for Medical Education for the year 1956. These grants include the matching monies received from the Ford Foundation under a previous agreement. At the same time the American Medical Education Foundation distributed to Yale University School of Medicine \$9,575 of which \$2,725 had been earmarked by donors for Yale.

OUR NEIGHBORS

The New Harvard Medical Center

Harvard Medical School and its seven teaching hospitals have incorporated themselves as the Harvard Medical Center, Inc., for the purpose of raising a common endowment of a sum unofficially estimated as high as \$100,000,000.

Recently chartered by the Commonwealth of Massachusetts, the new charitable corporation's purposes are to:

"Improve and advance knowledge, practice and teaching of medicine in all its branches; assist in the advance of medical research and investigation and in improvement of medical teaching facilities and methods; solicit and receive contributions from whatever sources in trust or otherwise and whether unrestricted or for undesignated purposes or subject to specified conditions."

Members are Harvard Medical School, Harvard School of Dental Medicine, Harvard School of Public Health, Beth Israel Hospital, Boston Lying-In Hospital, Children's Medical Center, Free Hospital for Women, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, and Peter Bent Brigham Hospital, Boston.

President of the Harvard Medical Center is Dr. George Packer Berry, dean of Harvard Medical School. Ralph Lowell, a trustee of the Massachusetts General, and Robert Cutler, chairman of the trustees of the Peter Bent Brigham Hospital, are vice-presidents.

Harvard Shows Way to U. S. on Plane Safety

Harvard University and Daniel and Florence Guggenheim Foundation jointly will announce establishment of Harvard-Guggenheim Center for Aviation Health and Safety in the School of Public Health. Under a \$250,000 grant, the center will be the seat of fundamental and applied research, give advanced training to physicians and engineers, and serve as a clearing house of technical information on aviation health and safety. Ross A. McFarland; winner of John Jeffries Award in 1956 for "outstanding contributions to the advancement of aeronautics through medical research," will be technical director of the center.

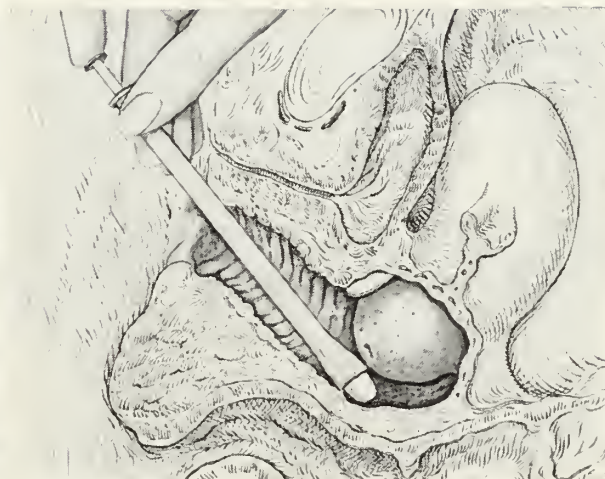
This announcement gives a new accent to Federal inertia in investigating human factors in civil aviation crashes.

New Hampshire

Interested in crash injuries on our highways, Ernest Sachs, Jr. of the Mary Hitchcock Hospital in Hanover is working on a research project concerned with the chemical analysis of changes in the brain and spinal fluid which attend head injuries. He is being assisted by a biochemist on the faculty of Dartmouth Medical School and a research chemist, under a grant from the National Institute of Health of the U. S. Public Health Service.

COMPREHENSIVE VAGINITIS REGIMEN

Powder Insufflation



Tablet Insertion

Floraquin® Rebuilds the Defense Mechanism in Vaginitis

Combined office and home treatment with Floraquin provides a comprehensive regimen which encourages restoration of the normal "acid barrier" to pathogenic infection.

Vaginal secretions normally show a high degree of protective acidity (pH 3.8 to 4.4). When this "acid barrier" is disturbed, growth of benign Döderlein bacilli is inhibited and that of pathogens encouraged. Floraquin not only provides an effective protozoacide and fungicide (Diodoquin®) destructive to pathogenic trichomonads and yeast, but also furnishes sugar and boric acid for reestablishment of the normal vaginal acidity and regrowth of the normal protective flora.

Suggested Office Floraquin Insufflation

"... the vagina is treated daily by swabbing with green soap and water, drying and insufflation of Floraquin powder."*

Suggested Home Floraquin Treatment

"The patient is also issued a prescription for Floraquin vaginal suppositories which she is instructed to insert high into the vagina each evening. On the morning following each application of these suppositories, the patient should take a vinegar water douche. . . ."

A Floraquin applicator is supplied with each box of 50 Floraquin tablets. G.D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Williamson, P.: Trichomonad Infestation, M. Times 84:929 (Sept.) 1956.

SEARLE

NEW EXAMINATION FORM DEVELOPED AS PART OF IMPROVED VISION TESTING PROGRAM FOR SCHOOL CHILDREN

The new referral form for eye examinations among school children is reproduced.

Ophthalmologist members of the State Medical Society consulted with the Society's Eye, Ear, Nose and Throat Section, the State Health Department and the State Department of Education in devising the form. It should be of special interest to physicians as it has been officially endorsed by the Society.

The first page, reproduced below, provides space in the top portion for referral data concerning screening tests, while the lower portion concerns the report of the examiner.

The reverse side of the form contains information for parents, teachers and school nurses. It gives the visual standards required of the children. It also gives a list of signs and symptoms in terms that the lay person doing the screening can understand and use as a guide in addition to taking the acuity.

The statutory provisions which govern the licensing and practice of ophthalmologists, optometrists, and opticians are set forth at the bottom of the page. These terms have always been confusing. While the parent should be free to consult whomever he wishes, these definitions should help him to decide which one he should go to.

Reprints of the form are available and a copy may be obtained by writing to the Committee on Eye Care at the State Medical Society

CLEMENT C. CLARKE, M.D., *Chairman*

CONNECTICUT STATE DEPARTMENT OF EDUCATION CONNECTICUT STATE DEPARTMENT OF HEALTH HARTFORD REFERRAL FOR EYE EXAMINATION

Form #1
Eye Sight

Child	(Name) _____	(Age) _____	(Grade) _____
Parents	(Name) _____	(Address) _____	
Result of screening of vision:	Without glasses	With glasses	
	R. E. _____ L. E. _____	R. E. _____ L. E. _____	
Date of test: _____	Test used: _____		
Other symptoms: _____ (See check list on reverse side)			
Nurse	(Name) _____		
School or agency	(Name) _____ (Address) _____		

REPORT OF EYE EXAMINATION

(Examiner please complete and hand entire sheet to parent to return to nurse, or mail directly to nurse.)

The following is my report on the above child:

Vision:	Without correction	With correction	
	R. E. _____	R. E. _____	
	L. E. _____	L. E. _____	
Glasses needed:	No _____ Yes _____	constantly _____	close work only _____ distance only _____
Other recommendations: (examples: special seating, sight-saving text-books, etc.: whether child should return for professional care and how soon)			

Date of this examination: _____	Examiner: _____ (signature and degree)	Address: _____
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All Sealtest Dairy products carry the Sealtest Label. All cartons and bottle caps have the same basic design. And each Sealtest Dairy Product uses a different color.

All of the Sealtest Dairy Products sold in Connecticut are uniform in quality. This is assured by the Sealtest System of Quality Control at all of the processing plants.

Sealtest Dairy Products are convenient. Regular deliveries to homes and stores are made from Bridgeport, New Haven, Waterbury, Hartford, Manchester, Melrose, New Britain and New London.



BUTTER

GET THE BEST
GET SEALTEST

BRIDGEPORT, NEW HAVEN, WATERBURY, HARTFORD, MANCHESTER
MELROSE, NEW BRITAIN and NEW LONDON

BRYANT & CHAPMAN

INFORMATION ABOUT VISION SCREENING PROGRAMS

Preschool children can cooperate in simple vision screening tests. Programs for testing them are organized in some communities.

The Connecticut State Law requires that the vision of all pupils in the public schools be tested annually.

The recommended standards of vision are at least:

Preschool:	20/40 in each eye
Grades 1-3	20/30 in each eye
Grade 4 on:	20/20 in each eye

For screening purposes, the **test preferred** is the Snellen "E" or letter chart correctly lighted at 20 feet combined with careful observation of the child's eyes.

The parent, the teacher, and the nurse in the public health agency or school, can and should observe, besides the vision, **other indications** for eye care whenever they occur. Such observed symptoms may be related to a local or a general disease or they may mean the child needs glasses or that the ones he has are no longer correct because his eyes have changed.

Behavior:

blinking.....watering eyes.....sensitive to light.....rubs eyes.....excessive frowning.....irritability when using eyes.....squints or squeezes lids to see holds book very close.....dislikes games requiring distant vision (baseball, etc.).....stumbles and trips over small objects.....

Appearance:

red eyes.....granulated lids.....sties.....discharge.....swelling about eyes.....head tilt.....droopy lids.....eyes out of line (cast).....

Complaints:

can't see blackboard (distance).....print blurs.....double vision.....head-aches.....nausea.....dizziness.....itching, smarting burning.....

When the vision is below standard or any of these symptoms are discovered in a vision screening program, the **referral form** on reverse of this sheet is issued to the parent or guardian who should see that the child gets the proper professional attention. When the child receives this attention the form should be completed by the examiner and be **returned to the nurse**.

Professional attention may be obtained from the family physician or from one of those persons trained in the various aspects of eye care. Briefly stated for your information—

An Ophthalmologist or Oculist is a physician (M.D.) licensed to diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person and who specializes in treating visual defects and other eye defects and diseases, and who prescribes and provides lenses for visual training. (Based on Section 2191d of the General Statutes of Connecticut—Revision of 1949, including 1955 Supplement to the General Statutes.)

An Optometrist is a doctor of optometry (O.D.) licensed to employ any means other than drugs for the measurement of the power of vision and adapt lenses for the aid of vision, and who prescribes and provides lenses. (Based on Section 4488 of the General Statutes of Connecticut—Revision of 1949.)

A licensed Optician is a person having a knowledge of optics and skilled in the technique of producing and reproducing ophthalmic lenses and kindred products and mounting the same to supporting materials and the fitting of the same to the eyes. (Based on Section 4520 of the General Statutes of Connecticut—Revision of 1949.)

1 IN 4 NOW 1 IN 3

Ten years ago, only one in four cancer patients was being saved. Steadily since then, heart-warming progress has been made. Today, with 450,000 new cancer cases estimated for 1957, you, their physician, can expect to save one in three of these patients.

Many factors contribute to this success — your leadership, a more aware public, improved methods and techniques of detection, diagnosis and treatment. There is every reason to expect this progress to continue to the point where half of those stricken by cancer will be saved. As yet, science does not have the know-how to save the other half.

That knowledge will be gained — and, indeed, the riddle of cancer itself, will one day be solved in the research laboratories. To continue to support this vital work, as well as to carry on its dynamic education and service programs, the American Cancer Society is seeking \$30,000,000. We are again appealing to the public to “fight cancer with a checkup and a check.”

The check is insurance for tomorrow. The insurance for today is largely in your hands, doctor. Fighting cancer with a checkup is our *immediate* hope for saving lives.

AMERICAN CANCER SOCIETY

CONNECTICUT DIVISION

1044 CHAPEL STREET, NEW HAVEN



SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL MIDDLETOWN, CONNECTICUT

Medical Education Program for April 1957

Monday, noon, April 1

Clinical-pathologic-conference

Wednesday, 10:00 A. M., April 3

Tumor clinic

Friday, noon, April 5

David M. Spain, M.D., professor of Pathology, Columbia University School of Medicine

Epidemiology of coronary heart disease

Monday, noon, April 8

Joseph D'Esopo, M.D., associate clinical professor, Yale University School of Medicine

Lung abscess

Friday, noon, April 12

Grand rounds

Monday, noon, April 15

Mr. J. A. Martin, E.E., supervisor Industrial Hygiene, Canel project, Pratt & Whitney Aircraft

Radiation hazards and protection

Wednesday, noon, April 17

Gilbert H. Glaser, M.D., chief, Section Neurology, Yale University School of Medicine

Headache

Friday, noon, April 19

Grand rounds

Monday, noon, April 22

Charles Reichtol, M.D., chairman, Department of Orthopedics, Yale University School of Medicine

Differential diagnosis of the painful shoulder

Friday, noon, April 26

Grand rounds

Monday, noon, April 29

A. V. N. Goodyer, M.D., chief, Section Cardiology, Yale University School of Medicine

The management of intractable heart failure

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(Held on second Monday of the months indicated at 7:30 P. M.)

All Interested Physicians Invited to Attend

April—The problem of aphasia

Dr. Frederick J. Flynn, Pediatrician

Dr. Francis G. Reilly, Neurosurgeon

Dr. Theodore Goldstein, Psychiatrist

Dr. Ross R. Thomas, Psychologist

June—Tendon transplants

Dr. Melvin R. Krohn, Research Fellow, Newington

Wagner release

Dr. John P. Griffith, Research Fellow, Newington

September—Open reduction in dislocation of the hip

Dr. Louis A. Coulson

American Association of Pathologists and Bacteriologists
Washington, D. C.

April 11-13, 1957

American Association for Cancer Research
Chicago, Illinois

April 12-14, 1957

American Association of Immunologists
Chicago, Illinois

April 15-19, 1957

American Society for Experimental Pathology
Chicago, Illinois

April 15-19, 1957

American Society for Pharmacology and Experimental
Therapeutics

Chicago, Illinois

April 15-19, 1957

American Institute of Nutrition
Chicago, Illinois

April 15-20, 1957

American Industrial Hygiene Association
St. Louis, Missouri

April 23-26, 1957

8th Annual Symposium on Recent Advances in the Study
of Venereal Diseases

Washington, D. C.

April 24-25, 1957

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SECOND ANNUAL NEW ENGLAND RURAL HEALTH CONFERENCE

Thursday, April 25, 1957

Congregational Christian Conference Center,
Pembroke, New Hampshire

MORNING PROGRAM

9:00 Registration

Everyone please register. There is no registration fee. Luncheon tickets may be obtained at the registration desk for \$1.75, gratuity included.

9:30 Greetings

Leroy S. Ford, M.D., Keene, N. H., President,
New Hampshire Medical Society

9:45 Remarks

Norman H. Gardner, M.D., East Hampton, Connecticut, regional director, Council on Rural Health, American Medical Association

10:00 Meeting Health Needs in New England

Moderator: Leon R. Lezer, M.D., Burlington, Vermont, University of Vermont, College of Medicine

1. "How We Got a Doctor"

Arthur B. Brown, Center Sandwich, New Hampshire

2. "I've Practiced in Chelsea Four Years and Like It"

Brewster Martin, M.D., Chelsea, Vermont

3. A Public Health Board Plays Its Part

Ralph E. Cole, M.D., Ayer, Massachusetts, vice chairman, Executive Committee, Nashoba Associated Boards of Health

11:15 Discussion

Leader: Aubrey D. Gates, Little Rock, Arkansas; Field Director, Council on Rural Health, American Medical Association

An opportunity to discuss the papers and question participants. This will afford everyone a chance to participate in this most important part of the conference.

12:00 Adjournment

AFTERNOON PROGRAM

12:30 Luncheon

Entertainment by Patricia Olkkonen, Durham, New Hampshire, recreation specialist, University of New Hampshire

1:30 Prepayment of Medical Care

Franz Goldman, M.D., Boston, Massachusetts; associate professor of medical care, Department of Public Health Practice, Harvard School of Public Health

2:00 Discussion

Led by Mr. Gates

2:30 Aging

Medical Aspects

Robert P. Smith, M.D., Burlington, Vermont; medical staff, DeGoesbriand Hospital

Nursing Aspects

Muriel Bigelow, R.N., South Paris, Maine; Public Health Nurse

3:15 Discussion

Led by Mr. Gates

In New England there are rural health problems peculiar to the area, problems which transcend state line boundaries. This conference will enable civic, health, medical and community leaders to discuss these problems openly and freely for the common good of all. Everyone is most cordially invited to attend.

Please make luncheon reservations before April 18 with the New Hampshire Medical Society, 18 School Street, Concord, New Hampshire, telephone Capitol 4-1909, or 4-1900.

United States Section, International Fertility Association
The Greenbrier, White Sulphur Springs, West Virginia
April 22-24, 1957

HARTFORD VA MENTAL HYGIENE CLINIC

The Hartford Veterans Administration Mental Hygiene Clinic announces it will hold a scientific meeting open to all members of the profession in celebration of its decennial on April 25, from 9:30 A. M. to 4 P. M. at the Hartford Courant Auditorium, 285 Broad Street, Hartford.

Dr. Louis A. Chase, training analyst of Boston, Massachusetts, will be the guest speaker during the morning session. A workshop in psychotherapy regarding a particular case is planned for the afternoon.

Dr. Isidore Schnap, chief of the Mental Hygiene Clinic, Dr. Richard Karpe, consultant, and Dr. Stephen H. Sherman, staff psychiatrist, will participate in the program.

AN INVITATION TO ATTEND THE FIRST PAN AMERICAN CANCER CYTOLOGY CONGRESS

To be held at Eden Roc Hotel, Miami Beach, Florida, April 25 to 29, 1957.

Sponsors of the Congress are:

The Cancer Cytology Foundation of America, Inc.
Cancer Institute at Miami, Florida
Southern Society of Cancer Cytology
University of Miami, Florida

Financial aid has been received from:

The Department of Health, Education and Welfare of the United States Public Health Service
Public Health Foundation for Cancer and Blood Pressure Research, Inc., Stamford, Conn.
Williams Foundation, Buenos Aires, Argentina.

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Society of American Bacteriologists
Detroit, Michigan
April 28-May 3, 1957

International Academy of Proctology
New York, N. Y.
April 29-May 2, 1957

International Congress of Otolaryngology
Hotel Statler, Washington, D. C.
May 5-10, 1957

Aero Medical Association
Shirley Savoy Hotel, Denver, Colorado
May 6-8, 1957

International Congress of International Society of
Bronchoesophacology
Philadelphia, Pennsylvania
May 12-13, 1957

International Conference of Audiology
Chase Hotel, St. Louis, Missouri
May 13-16, 1957

American College of Cardiology
Hotel Willard, Washington, D. C.
May 15-17, 1957

CONNECTICUT TRUDEAU SOCIETY

The Connecticut Trudeau Society (Medical Section, Connecticut Tuberculosis Association) plans to hold its Spring Meeting on Wednesday, May 22, 1957 at 8 P. M. at the Fitkin Amphitheater, Yale University School of Medicine, New Haven.

The speaker will be Dr. Howard G. Dayman, assistant professor of medicine at the University of Buffalo, and his subject will be "Management of the Short-of-Breath Patient." Dr. Dayman plans to dwell particularly on practical measures which have been found of value in the treatment of patients with chronic bronchitis and emphysema.

The Connecticut Trudeau Society invites all interested physicians to attend this meeting.

American Society for the Study of Sterility
Waldorf-Astoria Hotel, New York City
May 31, June 1 and 2, 1957

"OPEN HOUSE" AT WORLD MEDICAL ASSOCIATION SECRETARIAT OFFICE IN JUNE

During the entire week of the AMA meeting, June 1-6, 1957, there will be "open house" for U. S. Committee members at the World Medical Association office on the 12th floor of the Coliseum Towers, immediately adjoining New York's famous Coliseum, where the AMA's Scientific and Technical Exhibits are to be housed. Come up and see us, for a welcome respite from the exhibit crowds, join us in a cup of coffee, and see the home office of the "international voice of medicine."

"OPEN MEETING" AND RECEPTION FOR U. S. COMMITTEE JUNE 4, 1957

Plans are maturing for the Second Annual Meeting of members of the United States Committee of World Medical Association to be held during the course of the AMA meeting in New York. The U. S. Committee will meet at the Waldorf Astoria on Tuesday, June 4, at 3:00 P. M. Immediately following the meeting, the members will adjourn to a nearby room where they will again be the guests of the Pepsi Cola Company, at a reception from 5-7 P. M. The World Medical Association has become a traditional feature of the Annual Scientific Assembly of the AMA, and the gracious hospitality of our Pepsi Cola friends has made this party one of the social highlights of the AMA convention.

NEED FOR BROADER COVERAGE

(Continued from page 376)

sophically wise. But insurance can cover a broad enough range of services to protect the family when total costs are unusually high in an average year, as for the family that visits a doctor several times and has only occasional prescription costs and routine dental charges. These are more properly out-of-pocket expenses. But for the small group with abnormally high expenses for medical care (and any family might suddenly find itself in this category) there is great need for broader coverage to spread the risks of serious contingencies.

Many Americans, however, are still not purchasing adequate coverage against the risk involved, though they are quick to criticize medical and hospital charges in time of illness. Even though broader coverage insurance is growing faster than any other type, the general public does not yet fully understand that such coverage requires a greater investment in health insurance, and that broad coverage provides rich dividends in protection against disruption of the family economy.

(Concluded on page 400)



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NEW BOOKS IN REVIEW

PROBLEMS OF AGING The Twenty-Eighth Annual Graduate Fortnight. The New York Academy of Medicine. A Symposium, October 10 to 21, 1955. Edited by Robert L. Craig, M.D. New York: Medical and Scientific Books. 1956. 221 pp.

Reviewed by JAMES R. MILLER

Twenty distinguished contributors have reviewed, each in the field of his special competency, the Problems of Aging. This is an easy method of acquiring knowledge of phases of this rapidly expanding field of medical interest. One can obtain not only a review of modern practice and the concepts of diagnosis and therapy, but one can see through trained eyes a view of what still is to be understood and often indications of the steps leading to this fuller knowledge.

These lectures cover the fields of anatomy, biology, biochemistry, physiology, pathology and allied sciences such as sociology, psychiatry and psychology, and economics.

The nature of the aging process as such is discussed by Albert I. Lansing, anatomist. Our own Francis J. Braceland sheds light, as is his wont, in the dark places of the aging mind. We get a glimpse of what brain surgery may have to offer in treating the distressing symptoms of the Parkinsonian syndrome. There are many useful hints for those who have to take the aged through serious medical and surgical crises as well as to manage more long term care.

Twenty-seven years ago the Academy of Medicine held its first "Graduate Fortnight" on this same subject. Forty-seven lecturers unfolded the practice, attitudes, frustrations and hopes of that day. Then as now one could read what many famous men had to say. Thewlis' book was quoted as was many an ancient sage, some of it entertaining reading. But what a contrast to this volume of 1955! George Vincent, then president of the Rockefeller Foundation, stated with prophetic vision that physicians must turn their minds to training as well as healing. Sir Farquhar Buzzard, who followed Sir William Osler at Oxford, sounded quite modern when he advocated multiplication of interest early in life as a check against the advances of senility.

Louis Dublin boasted that annual physical examinations, a program forwarded by his company (Metropolitan Life), had netted two dollars for every dollar spent for examinations. It would be good to have a considered judgment expressed today on that subject.

The greatest contrast between then and now came from reading Alexander Lambert's *Pharmacology of Old Age*. One does not need to be a therapeutic nihilist to marvel at what seems now to have been credulous confidence placed by such an authority in aconite and many another remedy. It does not seem likely that 30 years hence our successors can find such amusement in reading the lectures of 1955.

Alexis Carrel, surely one of the great names in medical

science, in his lecture offered a blood serum test. This appeared to be a rate of growth index which, diminishing with the advance of years, would measure the aging process. What has become of this? Perhaps some of the hopes for advance expressed in our current volume will prove equally unproductive.

In the 1928 series Samuel Lambert discusses alcohol in relation to aging. This was written in the aura, or should we say aroma, of the discussions of the 18th Amendment and the Volstead act. It is good reading.

The newer volume has nothing to compare with Tilney's *Aging of the Human Brain*. Perhaps little of consequence has been added to the information on the studies of aged brains which he describes. His statement that "it is disease not years which altered their brains and caused the waning of brain power," strikes the reviewer as of such importance that one would expect a symposium on the subject of aging to say it is still right or if not to argue the point. This kind of criticism aims at the fact that this is by no means a complete picture or explanation of the problems of aging. That is why so much space has been given to the previous volume.

When one compares 1955 with 1928 as these lectures express the problems of aging, we can say without hesitation that evidence is before us that the advances of knowledge in these 27 years have made it possible better to understand and to care for the aged. One cannot read Rusk and Dasco's outstanding lecture on Rehabilitation in the Aged without wishing that George Vincent might have lived to see to what extent training has been added to healing.

YOU AND YOUR OPERATION. By Benjamin R. Reiter, M.D., Director, Department of Health, University of Minnesota. New York: Macmillan Company. 1957. 150 pp. \$3.50.

Reviewed by STANLEY B. WELD

When Benjamin Reiter wrote this book he was actively engaged in the practice of surgery in Bridgeport, Connecticut. The Connecticut State Medical Society of which he is a distinguished member is honored in his appointment to his new post in Minnesota.

This is one of the best volumes dealing with the patient, the operation, the hospital, and the surgeon which has come off the press. Picking it up casually, one is not impressed by the title. It smacks of those syndicated columns with which the public is being deluged—and bored—in the daily press. But between the blue covers there is a wealth of information, common sense, and valuable instruction for the patient. The surgeon will not find his time wasted in reading it. If this group is criticized for any one thing today, it is the routine despatching of a patient to the hospital with little or no explanation as to what lies ahead. All this and much more is covered by the author.

In addition many hospital procedures are explained and several specific operations are discussed. Cancer is allotted a separate chapter, significant of the place it holds in the lay mind today. The two final chapters sum up admirably what should be expected of the surgeon and of the patient.

One note of discord disturbs the harmony and that is the use of such medical jargon as "a peptic ulcer which has hemorrhaged." True, we hear such grammatical outrages every day but they should not be any more acceptable than some of Frank Sinatra's crooning or Elvis Presley's rock 'n' roll. Nonetheless it is good book. You should read it and profit thereby.

FIVE HUNDRED OVER SIXTY. A Community Survey of Aging. Bernard Kutner et al. Russell Sage Foundation. Philadelphia, Pennsylvania: Wm. F. Fell Co. 1956. 345 pp. \$4.

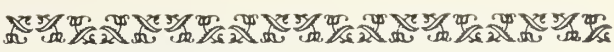
Reviewed by JAMES R. MILLER

Representatives of the Department of Sociology and Anthropology, of Cornell University and the Department of Public Health and Preventive Medicine of Cornell University Medical College, together with the Welfare and Health Council of New York City and the Russell Sage Foundation formed a committee to study many of the unsolved problems of Aging. They determined that the best way to ascertain what the needs of the old people are, is to ask them personally and individually.

Under the chairmanship of W. G. Smillie, M.D., an able staff was assembled and 500 "over sixty" persons were subjected to an exhaustive research, the like of which has not been done till now. This book tells how the scientific sampling was done in the Kipp Bay-Yorkville health district of New York, that area bounded roughly by Fifth Avenue and East River, 34th Street on the south and the borders of East Harlem on the north. The methods of selection, the questions asked, and the philosophical considerations which guided the study are all set down. For those who are familiar only with the clear cut methods of clinical and laboratory research, this insight into the methods of social and anthropological study will be most interesting. In addition to the substantial additions to our understanding of what makes the old folks tick and what keeps them ticking, there are some surprises and some presumptions are shown to be erroneous.

Part I: A Survey of Aging, outlines the objectives of the study and describes the community setting and its population. Part II: Patterns of Adjustment in Old Age, and Part III: Health in Old Age, give the detailed findings including the problems of health and of adjustments of various groups. Part IV: Trends and Programs, describes the facilities of the City of New York and points to the implications of the study for New York and perhaps for other communities.

It became apparent early in the study that the essential need of old people is for an advisory or consultative service which Dr. Smillie states should be an integral part of the community's health and welfare services. The majority of those questioned said that they approached retirement with trepidation and for the most part their fears were realized. The blow to the ego in retirement is the implication of uselessness, which, all too often is increased by the attitude of others toward the retiree. Physicians will be interested to learn that "health problems do not represent the central focus of attention of older people." Decline of health was not found to be the specter so often assumed. It became apparent too that segregation of the aged has psychological consequences that are not yet fully



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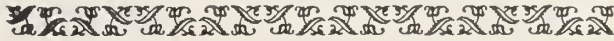
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understood nor appreciated. Evidence of the study points to a major principle: "If programs are effectively to reach those who are inclined to use them, such services must be as diverse and embedded in as many organizational contexts as there are preferences, attitude patterns and values regarding aging among the older people." "Until the desires and feelings of older people themselves are tapped to determine the lines that acceptable services must take, abortive experiments in geriatrics are bound to continue. What old people need most is counseling that will help them face frankly the realities of aging and choose an intelligent course of conduct to follow." Every now and again we see large bequests left for the purpose of doing something for old people. Those who have the expenditure of these funds, and those who advise them cannot neglect a close study of this informative community survey.

The quality of printing, indexing and editorial work is fully up to the high standard which we expect from a Russell Sage Foundation publication. The reviewer noted only one fault. On page 236 there is reference to the study in California which showed that two thirds of those over sixty who are committed to State hospitals are not psychotic. While this may have been true for California, such statements are too easily taken by legislators as the basis for important action. The study of Shindell and Corn-

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field (reported in this JOURNAL) conclusively disproved the statement as far as Connecticut is concerned. Perhaps the California experience is one of those exceptions so often found in that truly exceptional State.

THE HAPPY LIFE OF A DOCTOR. By Roger I. Lee,
M.D. Boston: Little, Brown & Company. 1956. 278 pp.
\$4.

Reviewed by STANLEY B. WELD

To a native born New England doctor of medicine this book should offer delightful reading. Homely touches are there, beginning with the pictures of the ancestral homes in Vermont and New Hampshire and continuing on through college days with his limited financial resources and his physical handicaps. Working in a public library at ten cents an hour several afternoons a week may seem a ridiculous occupation for a red blooded boy but there are others who have performed the same task with similar compensation. His account of the demonstration of the presence of shrimp off the New England coast touches a vital problem today, viz., the gradual disappearance of some of the shell fish and many of the noncrustacea in certain areas of the Atlantic seaboard.

Although an individualist, Roger Lee's life story emphasizes many of the characteristics which are found in the ideal physician. He says that most of his colleagues "think not only that I am a d— fool but that I am a menace to the profession." And yet Roger Lee's contributions to Harvard University and to medicine have been almost legion. President Lowell thought highly of him. Postgraduate medical education owes much to him. He tells how he struggled for better medical practice, whether under the control of those rugged individualists the doctors, under the government, or under the insurance companies. He opposed fees based on the patient's income and stood firmly for fixed fees for service rendered, reducible if found desirable. One of his greatest contributions has been his emphasis on the treatment of the patient as an individual, not as just a case, thus enhancing the doctor-patient relationship so vital to the successful practice of medicine.

There are constant references to his own overweight and to the rheumatoid arthritis of his later years. His experiences in World War I are fascinating and vividly portray his shrewdness and adaptability. Those who heard the Boston Symphony Orchestra at the recent clinical session of the American Medical Association in that city probably had no idea that this contribution made possible by the generosity of one of our large pharmaceutical houses was the result of an idea of Roger Lee's. Humor abounds in this biographical tale. Those who know Dr. Lee know his love for cigars. Imagine Winston Churchill refusing a proffered stogy and when asked if he was afraid of getting used to smoking good cigars, replying, "Oh, no, but I am used to my cigars and they to me. I can handle their poison, but I wouldn't know about some other poison."

Perhaps it is because I have always liked Roger Lee and his Bostonian manner that I enjoyed his "Happy Life" from cover to cover. One should not have to be a Harvard graduate nor even a New Englander to appreciate his humor and his stimulating philosophy of life.

JOINT LIGAMENT RELAXATION TREATED BY FIBRO-OSSEOUS PROLIFERATION. By *George Stuart Hackett*, Consulting Surgeon, Mercy Hospital, Canton, Ohio. Springfield: Charles C. Thomas. 1956. 97 pp. \$4.75.

Reviewed by CHARLES W. GOFF

Dr. Hackett, to his satisfaction, concluded that a considerable amount of low back and certain ligamentous disabilities are probably due to a relaxation of ligaments. He reports in his monograph, a method of localizing the "trigger point" of pain by injecting pontocaine, 0.15 per cent, in over 4,000 instances. His patients ranged between the ages of 15 and 88 years, with women representing 52 per cent of the series. After 12 years of follow-up the remarkable percentage of 82 regarded themselves "cured."

After local anesthesia is obtained in intraligamentous injection of a proliferating solution, Sylnasol put up by G. D. Searle and Co. is reported to have produced local exudation, followed by "a maximum of fibrous tissue and bone which became permanent" (pages 34-35). In this way, the ligaments were tightened.

Animal work was reported in confirmation of the efficacy of the proliferating effect on ligaments. Twenty-four case reports conclude the monograph. Many physicians will find the method interesting. This report represents one man's experience over the many years. Its limitations will be apparent on reading, but as suggested by Waltman Walters, editor of *AMA Archives of Surgery*, 73:1956, "the material is controversial and will lead to discussions pro and con . . . recognizing both its controversial nature and its merit."

WIRE BRUSH SURGERY. By *James W. Burks, Jr.*, M.S., M.D., Associate Professor of Clinical Medicine (Dermatology), Tulane University of Louisiana School of Medicine. Springfield, Ill.: Charles C. Thomas. 1956. 149 pp. \$6.50.

Reviewed by LEONARD K. SMITH

It was about a decade ago that the subject of "Sandpaper Surgery" was brought to public attention. In that intervening period little general clarification of the method and of its results have been forthcoming.

This book by Dr. Burks traces the history of medical attempts to cosmetically improve the skin and describes the evolution of our present dermabrasive instruments. The anatomy of the skin is discussed in relation to the planing techniques. A complete outline of essential equipment and the step-by-step technique for executing this procedure are given.

A major portion of the text is devoted to listing and discussing the indications for dermabrasion, and numerous illustrations are included. The indications, according to Dr. Burks, are almost without bounds in the realm of skin disease. Conversely, contraindications are near nonexistent.

Contrary to Dr. Burks, this reviewer feels much less enthusiasm for the results and far greater restriction for the indications.

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THE MORPHOLOGY OF HUMAN BLOOD CELLS.

By L. W. Diggs, M.A., M.D., Dorothy Sturm and Ann Bell, B.A. Philadelphia: The W. B. Saunders Company. 1956. 181 pp.

Reviewed by CLAIR RANKIN

This atlas is commended as a text for the use of medical students and technicians and as an office reference for physicians and their laboratory assistants. The format and the loose-leaf binding enhance the book's usefulness in the laboratory.

The text is well written and reads easily. It is profusely illustrated with colored plates, black-and-white photomicrographs, illustrative and explanatory figures, and tables. I was interested to note that thirty of thirty-one colored plates which preface the text are drawings of cells rather than photomicrographs. It is my feeling that the excellent colored photomicrographs which can be reproduced at the present time far exceed in teaching value the finest artistic representations of blood cell morphology. In the text itself, on the other hand, black-and-white photomicrographs were used abundantly and effectively. Even here, drawings were often substituted, with questionable advantage.

This text has covered the field of morphologic hematology in an able and readable fashion. To cite but a single subsection, the discussion of the L. E. cell, the "L.E.-like cell" and the tart cell, is thorough, lucid and illustrated by over thirty drawings (*no* photomicrographs) of such cells, their stages and variants.

In addition to the section of large colored plates, the text covers 110 pages, the final twelve pages of which are devoted to applicable techniques and methods.

NEED FOR BROADER COVERAGE

(Continued from page 392)

Coverage for a wider range of services will become a large-scale reality only as the public, voluntary health insurance agencies and insurance underwriters join efforts to make it so. Fortunately, as this issue of *Progress in Health Services* shows, the rate of increase in benefits provided by voluntary health insurance is increasing rapidly; the public is continuing to buy more protection. When we consider that 25 years ago only optimists believed that the risks of even hospitalization costs could ever be spread to the benefit of all, there is good reason to predict that the public will meet this challenge and will elect to protect itself more fully.

WILMARTH BRADFORD WALKER, M. D.

Born: New Haven, Connecticut, November 30, 1895

Ph.B., Yale University, Sheffield Scientific School, 1916

M.D., Yale University Medical School, 1920

Internship: Hartford Hospital, 1920-1921

Staff Appointments: Attending Physician

Charlotte Hungerford Hospital 1925 . . .

President of the staff 1948 . . .

Secretary-Treasurer, Litchfield County Medical Association, 1933-1945

President, Litchfield County Medical Association, 1946-1947

Councilor, Connecticut State Medical Society, 1949-1955

Past President, Connecticut Public Health Association

Health Officer, Cornwall, Goshen and Warren

Medical Examiner, Cornwall and Goshen

Member: American Medical Association

Connecticut State Medical Society

Litchfield County Medical Association

Connecticut Public Health Council, 1947 . . .

Connecticut Public Health Association

American Public Health Association

Fellow, American College of Physicians, 1936 . . .



THE PRESIDENT'S PAGE

It is with sincere and deep humility that I assume the responsibility of being your President, and it is with the hope that in some small measure I can approach the accomplishments of my predecessors. I am particularly proud to represent Litchfield County in this year that information has been published to show that the first meeting of the Medical Corporation in Litchfield took place in the Court House on the second Tuesday of January 1767. The report of this meeting was discovered by Dr. Byron Stookey of Sharon in a copy of the *Connecticut Courant* of February 23, 1767, and I would like to quote their first resolution.

"We the Subscribers, Members of the Medical Corporation in Litchfield County, do covenant and engage, to end, with each other; that (acting on the Principles of Honor, Honesty and Fidelity) we will trust one another, in our Professions or Practice, that may tend to the Hurt or Detriment of any member of this Corporation, either in the interest or Character, whereby Contempt or Reproach may be brought on worthy Practitioner, and true medical Knowledge. And any Member who shall be found guilty of a Violation of the above Engagement, after a fair Trial, and refusing to heal and accommodate the same, shall be deemed unworthy to be continued a Member of this Corporation, and denied all the Privileges and Benefits of the same."

In the report of the second meeting in June 1767, it was stated that Thomas Russell, Esq. of Cornwall was "Pleased to join and incorporate." He was the first "Educated" Physician in Cornwall according to Starr's "History of Cornwall" and his removal to Piermont, New Hampshire was partly due to disagreement with the minister, Reverend Hezekiah Gold, who was a direct ancestor of our late James Douglas Gold.

This is the first time in years that your President has been a general practitioner. I believe Charles H. Turkington of Litchfield was the last of this order and he was elected in 1937. Could it be that the man in general practice cannot find time to give to his medical society without unduly suffering from interference with his practice, or are the specialists more conscious of their obligations to organized medicine?

There are many problems which will engage our attention this coming year: Physician-Hospital Relationship; Compulsory Social Security for Physicians; National Legislation, especially regarding treatment of nonservice connected disabilities in the Veterans Administration; "Third Party Payments." May I enlist the cooperation of each and every one of you, in their solution, or in progress toward their solution with credit to our chosen profession.

W. Bradford Walker, M.D.

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PROPHYLAXIS OF ALLERGIC DISEASE IN INFANTS AND CHILDREN

DOUGLAS E. JOHNSTONE, M.D., *Rochester, N. Y.*

ANY physician concerned with the medical care of infants and children must at some time find himself in the position of having to handle some allergic or immunologic problem. The purpose of this paper is not to outline the management of any one particular pediatric allergic problem, but rather to review what can be done to help prevent the development of allergic expression or to minimize it when it develops.

The care of any "preallergic" or "potentially allergic" child rightly begins when he is in utero. The term "potentially allergic child"¹ describes a child who is either a sibling or an offspring of a person with major allergy, i.e., asthma, eczema, hay fever or perennial allergic rhinitis.

IN UTERO

The food cravings of a pregnant mother and her excessive indulgence in certain foods during pregnancy appear to account in part for some cases of food sensitivity in infancy, which to all appearances occur spontaneously from the first ingestion of a new food.² Ratner³ pointed out that in the case of guinea pigs sensitized in utero, the protein molecules themselves pass the placental barrier to sensitize the fetus actively. In the case of food sensitivity, if a pregnant mother eats an excess of raw or inadequately cooked egg white, for instance, she may actively sensitize her offspring so that the first time her infant is given a soft boiled egg, he may develop either eczema or a nasal discharge or other allergic expression.

Passive sensitization in utero is likewise a well documented phenomenon in animal experimentation. Ratner was the first pediatric allergist to demonstrate this phenomenon by his classical experiments almost thirty years ago. The following quota-

The Author. Instructor of Pediatrics, University of Rochester School of Medicine and Dentistry; Director of Pediatric Allergy Clinic, Strong Memorial Hospital, Rochester, N. Y.

SUMMARY

The clinical and experimental background material which forms the basis of present day concepts of prophylaxis of allergic disease in infants and children in varying age groups is reviewed.

The influence of heredity on a given child's allergic manifestations can not be changed after conception has occurred. However, a physician can probably do much to lessen the severity of or delay the chronological onset of major allergic symptoms, bearing in mind the untoward effect in these children of (1) improper diet of the mother during pregnancy, (2) too early introduction of foods known to commonly cause allergic symptoms, (3) hot air heating systems, (4) unnecessary excessive exposure to inhalable animal danders, dust and pollens, and (5) the injudicious use or overuse of injectable antibiotics. In addition, early recognition and treatment of major allergies (atopic dermatitis, asthma, pollenosis and perennial allergic rhinitis) will do much to lessen the severity and natural progression of allergic disease.

tion from his work⁴ not only illustrates this point, but serves as a fine example of how a young pediatric allergist three decades ago strove to throw light on a field which at the time was likened to a modern form of alchemy. "A gravid guinea pig was injected intravenously with 10 cc. of horse serum four days antepartum. The litter was composed of a male and a female. The male sibling was injected intraven-

From the Department of Pediatrics of the University of Rochester School of Medicine and Dentistry and Strong Memorial Hospital

ously with horse serum at 109 days of age and died in anaphylactic death, indicating that it was the result of active sensitization in utero. The female sibling was mated with a normal male. At 104 days of age she gave birth to two offspring. Three days after parturition she was injected intravenously with horse serum for the first time and died in anaphylactic shock, proving that she too had been actively sensitized in utero. One of the offspring of the second generation was injected at three days of age and died in anaphylaxis. Inasmuch as an animal that is actively sensitized in utero does not give a reaction at three days of age, it would suggest that the actively sensitized female transferred a passive state of anaphylaxis to her offspring. The second sibling was mated with a normal male. At 126 days of age a litter of two was born. The following day she was injected intravenously with horse serum and proved to be nonsensitive. The passive sensitization derived actually from the grandmother via the mother had worn off. The two offsprings (of the third generation) were also free of sensitization." Human in-utero passive sensitization of the fetus involves passage of antibodies formed by the mother through the placenta and fixation to the fetal tissues. In the case of such passive sensitization of the fetus to milk, for instance, the infant might have difficulty (bloody mucous diarrhea,⁵ rhinorrhea, rash, etc.) in the first few days of life as a result of maternal lacte sensitization. Such an infant might well tolerate cow's milk subsequently without trouble, if he fails to become actively sensitized himself.

In humans passive sensitization may express itself in various other ways, some of which are beneficial and some of which are not. Rh sensitization of a mother, either as a result of previous pregnancies or having received Rh positive blood transfusions in childhood or adulthood, may result in fatal passive sensitization of an infant in utero. In this instance transplacental transfer of Rh antibodies produces passive sensitization against the infant's own red blood cells. Proof that transplacental transfer of antibodies does occur was presented by Ratner.⁶ He pointed out that there are some animals like cows, sheep and horses, which could not effect transplacental transfer of antibodies, whereas in the guinea pig, rabbit and human, antibodies could be transmitted through the placenta. The difference between these two groups is explained by histological differences in the placentae of these two groups. Thus

the offspring of animals like cows, sheep and horses must be fed their mother's milk in order to obtain antibodies against bacterial disease which would otherwise be fatal in infancy. In humans, however, because of transplacental passage of antibodies, both helpful and harmful, breast feeding is not mandatory⁷ to assure passive immunization of the offspring against such diseases as diphtheria, pertussis, poliomyelitis, varicella, rubeola and other diseases of later infancy.

If the nutritional requirements of the pregnant woman whose offspring will be "potentially allergic" makes it imperative for her to have larger than usual amounts of any food element or if she insists on eating those foods commonly sensitizing potentially allergic infants (e.g., eggs, wheat, milk), the obstetrician may prescribe them in an "allergenically denatured" form.⁸ This means drinking only boiled milk, and eating eggs only if well boiled.

NEONATAL PERIOD

With an increasing awareness of knowledge of immune phenomena and of clinical pediatric allergy in general, parents are beginning to ask their physicians whether anything can be done to minimize the development of allergic disorders in the newborn period. Pediatricians for a long time have suspected that most children who develop eczema early, later get other major allergies, and that eczema in the first six months of life is caused by certain commonly eaten foods (i.e., cow's milk, eggs and wheat). MacKinnney pointed out that in a study of 500 allergic children, eighty per cent of those who developed atopic dermatitis subsequently developed a major respiratory allergy (asthma, hay fever or perennial allergic rhinitis). Ratner and others have presented similar data.

An organized study to use this common knowledge in an effort to influence the incidence of major allergy in potentially allergic children did not appear in the literature until September, 1953.¹ This report concerned the results of a study in which 96 potentially allergic children were studied. Their mothers were instructed during their pregnancies¹⁰ to avoid food cravings and excesses and to either avoid eggs, whole cow's milk, wheat cereals, fish and nuts or to eat them only in a denatured form. This necessitated overcoming the common prejudice about the particularly high nutritional value of eggs. On the day of birth, these infants were placed on a diet completely free of beef products (meat,

milk in any form, or cheese), hen chicken products (egg yolk, egg white, hen chicken meat), wheat (mixed cereal, farina, pastina, cream of wheat, Zweibach, bread, or crackers), fish (fish oils or strained fish), and spinach. Capon, rooster or tom turkey were permitted in the second six months of life in place of hen chicken. Rykrisp and rice wafers were permitted in place of Zweibach, which contains milk, wheat and egg white. At birth these infants were placed on a formula of soy bean milk, although a few received meat base milk¹¹ with strained lamb or pork as the source of protein. This diet was continued in most of the infants for nine months. These 96 infants were followed carefully from a pediatric as well as from an allergic point of view. The incidence of major allergy in this group subsequently (followed for an average of five years) was compared with their 65 siblings and another nonrelated control group of 175 children with a very similar allergic family history. The results of this study are shown in Table I.¹

and P is less than 0.01 for the incidence of sequelae to atopic dermatitis). The incidence of milk allergy and the subsequent occurrence of major allergic diseases in these infants are likewise statistically significant (Chi square equals 20 and P is less than 0.01). In one family studied in this survey, all five children exhibited allergy to milk from the first feeding of this food. Four of these children developed atopic dermatitis from the ingestion of milk. Two of these four children also got asthma from drinking milk. The fifth sibling was placed in the experimental group, not receiving any cow's milk until after nine months of age. Although this child, like his siblings, is technically allergic to milk even in a denatured form such as evaporated milk, in spite of having avoided it completely in his first nine months (it caused mild colic and diarrhea in this infant), he has not developed any major allergic disease in the first seven years of life.

It is to be stressed that this regime of withholding milk, wheat, egg, etc., from the diets of newborns

TABLE I

INCIDENCE OF MAJOR ALLERGY IN POTENTIALLY ALLERGIC CHILDREN

	NO. OF PATIENTS	INCIDENCE OF MAJOR ALLERGY	ATOPIC DERMATITIS AND SEQUELAE	ALLERGY TO COW'S MILK AND SEQUELAE
Experimental group	96	14%	7 (1 had asthma at 3 years, 6 free of allergy at 6 years)	7 (none at 6 years)
Sibling control group	65	61%	21 (15 had major allergies between 4 and 6 years, ¹ 6 free of allergy at 6 years)	24 (22 had major allergies at 6 years ²)
Nonrelated	175	57%	50 (30 had major allergies by 5 years, ³ 20 free of allergy at 6 years)	53 (26 had major allergies at 6 years) ⁴

¹10 asthma, 4 pollinosis, and 1 perennial allergic rhinitis.

²11 asthma, 6 chronic atopic dermatitis, 4 pollinosis, and 1 perennial allergic rhinitis.

³24 asthma, and 6 pollinosis.

⁴24 asthma, 1 pollinosis, and 1 pollinosis and perennial allergic rhinitis.

It is seen from this table that four times as many infants in each of the two control groups developed major allergic diseases during the observation period as in the experimental group placed on the special diet at birth. The probability that this difference is due to chance is less than one in a hundred (Chi square is 16, and P is less than 0.01). The differences among the groups in the incidence of atopic dermatitis and the incidence of major allergic diseases subsequent to the development of atopic dermatitis appear to have been equally significant (Chi square is 19 and P is less than 0.01 for the incidence of atopic dermatitis, and Chi square is 6

is suggested not only for siblings of children with major allergies, but also as a prophylactic measure for all potentially allergic newborns.

INFANCY

The chief problems of this period are: (1) food intolerances of allergic children during gastrointestinal disturbances, (2) too early introduction of solid foods, and (3) the need for early recognition and treatment of eczema and respiratory allergic conditions.

Ratner² and Hutinel¹² pointed out that after severe gastrointestinal disturbances of infancy the

child may manifest sensitivity to a food for which he had complete tolerance prior to his illness. These authors presumed that increased permeability of the intestinal wall engendered by diarrhea, for example, permits the ready entrance of unchanged protein into the blood stream. Ratner¹³ was one of the first to demonstrate by animal experimentation the fact that not only can proteins pass the intestinal barrier, but also that in newborn animals they pass more readily than in mature animals. The speed with which whole proteins, or at least some allergenic fraction thereof, may enter the blood stream of humans was pointed out in the classical experiment of Walzer.¹⁴ He fed egg white mixed with formula to newborn infants who had been passively locally sensitized and found that a positive reaction developed at the passively sensitized site before they had finished their bottles. He concluded, "the gastrointestinal tract of the newborn infant is almost like a sieve." It is important, therefore, during the acute state of convalescence of severe intestinal disturbances in potentially allergic children (1) to give a varied diet, (2) to avoid new foods and raw or lightly cooked foods, or (3) to give them "allergically denatured."¹⁴ This same increased permeability of the intestinal tract may also occur following surgical operations.²

One of the more pernicious trends in pediatric practice today is the recent tendency toward too early introduction of solid foods, which are not nutritionally necessary and may not be completely digestible. Potentially allergic children should get as few solid foods in the first four to five months of life as feasible. With the exception of strained meat, most early introduced foods consist primarily of starch and sugar-containing foods, which are not strictly necessary in this age of multiple vitamin preparations. That a mother may succeed in getting a six week or three month old infant to eat or drink some staple food (e.g., wheat, vegetables, egg) does not mean that it is necessary, justifiable or correct from a pediatric, nutritional or allergic point of view.

Adequate active immunization against diphtheria, pertussis and tetanus should be started as early in allergic children as in nonallergic ones. Parents should be taught the differences between active and passive immunization, in order to emphasize the importance of avoiding the unnecessary administration of any antitoxin in the form of horse, rabbit or beef serum. The need for keeping active immuni-

zations up to date and of obtaining booster injections when indicated to maintain and boost this active immunization is surprisingly often overlooked. The responsibility for this education to avoid serum sickness lies not only with the practicing and academic pediatricians, but also with general practitioners and all those charged with the responsibility for emergency surgical care of infants and children.

It is important to diagnose and treat eczema and respiratory allergies early, particularly in the light of MacKinney's⁹ findings of the high incidence of major respiratory allergy following the development of eczema. This finding makes it doubly important not to falsely label a child as having eczema, when he may merely have seborrheic dermatitis. The differentiation between these two common skin conditions of infants belongs in the medical armamentarium of every pediatrician. Eczema or atopic dermatitis results from a sensitization of a child to either foods or inhalants, either by ingestion, inhalation or contact. It is characterized by (1) intense itching, (2) a tendency to affect certain areas of the body, namely the antecubital and popliteal spaces (including the creases thereof) and cheeks, (3) a tendency to develop secondary infections, and (4) in many instances by association with positive skin tests to offending allergens. Seborrheic dermatitis, on the other hand, is characterized by (1) relatively little itching, (2) a tendency to affect certain areas of the body, namely the post auricular areas, the scalp ("cradle cap"), the trunk, the diaper areas, and the popliteal and antecubital space (unlike atopic dermatitis, however, seborrhea usually does not involve the creases of the popliteal, antecubital and diaper areas), (3) the presence of a waxy deposit in the chronic lesions, which gives a characteristic yellowish hue when the skin is stretched, and (4) a tendency to be free from infection, particularly in the chronic forms.

CHILDHOOD

Inhalation sensitization. Contact with wool, stuffed toys and feather pillows and comforters should be avoided. Since an infant spends a major portion of his life in his crib,¹⁵ these sources of inhalation sensitization take on special importance. Toys, clothing, and dust collectors of any type have no place in the bedroom of the potentially allergic child. Rubber or wooden toys should replace them. By the same token it must be recalled that most infant crib mattresses contain a multitude of epi-

dermoid lintens. As long as the plastic covering remains intact, these mattresses usually constitute no allergic problem. However, if the plastic covering becomes torn (and everyone who has toddler infants knows what fascination tearing of these plastic covers holds for the child of this age period), the lintens of the mattress become a potential source of inhalant sensitization. The habits of many infants of either fondling a woolen blanket or picking the nap off woolen blankets and holding wads of this material near the mouth or nose constitutes another possible source of inhalation sensitization of these children. The recent introduction of nylon blankets and sweaters has done much to reduce this hazard as well as the tendency to develop contact dermatitis and atopic dermatitis from wool contact. Wherever possible direct contact between all woolen objects with the skin of these children is to be avoided. Nylon winter garments are to be preferred in any infant who has ever shown any evidence of atopic dermatitis, contact dermatitis, or even merely pronounced dermatographia.

One of the most important factors in increasing the incidence of respiratory allergies in modern civilization is the use of hot air heat in homes. Whereas our forefathers shivered in drafty rooms, modern children sleep in a dilute sea of dust, and hot air heat has increased the complexity and allergenicity of household dust. The commonest allergenic constituents of dust are feathers, mold spores, animal danders, and stuffings of furniture and bedding. Since a child spends so much of his early life in his bedroom, this room needs special attention in the case of the potentially allergic child. If possible, the bedroom should be used only to sleep in, not as a play or store room. A suitable fiberglass filter should be installed in the furnace pipe leading to the bedroom register, which should be kept closed as much as possible. Pillows and mattresses should be either made of foam rubber or covered with dustproof coverings. Where feasible, radiant heating should be used. Some types of home made or purchased air filter should be installed in the bedroom window during seasons of grass and weed pollination. Parents should urge support of civic groups dedicated to the eradication of ragweed and similar weeds. If furry pets are permitted in the home of asymptomatic potentially allergic children, they should ideally be dogs with short hair or ones which do not shed much hair. Also, they should never be permitted in the child's bedroom.

One of the most frequent allergic problems among children is perennial allergic rhinitis. It represents a common problem which is one of the most poorly understood and one of the subjects most inadequately presented to medical students and house officers. The need for early recognition is based primarily on the fact that this condition is often a precursor of other more troublesome respiratory allergies, such as hay fever and asthma. The symptoms of this condition all result from hypertrophy, edema and hypersecretion of the mucous membrane of the nose and nasopharynx as a result of sensitization to either ingested or inhaled allergens. The chief complaints are often repeated "colds"¹⁶ manifested by rhinorrhea or nasal stuffiness, which hang on longer than the usual "cold" or which are continuous or intermittent all winter long. Repeated ear infections, chronic cough, or regrowth of adenoids may be the chief complaint which brings the patient to the doctor. In small infants nasal obstruction may interfere with nursing and eating in general or may cause restless sleeping, often associated with snoring and mouth breathing.

If seen during some complicating infection, the lack of nasal eosinophilia may mislead the physician as to the primary underlying condition. If repeated nasal smears are made, the true nature of the condition will usually manifest itself by nasal eosinophilia. Perhaps the most diagnostic mannerism of these children is the "allergic salute"¹⁷ which consists of elevating the tip of the nose with the palm of the hand in an upward movement. The child does this because he discovered that it seems to give some relief of nasal itching and obstruction by widening the intranasal space, separating the turbinates from the septum, and thus breaking the film of watery mucous secretions. Children who do this should not be badgered by their parents for having a "bad habit."

In an effort to lessen the incidence of penicillin sensitivity, penicillin should not be used unless there is a positive indication, and then it should ideally be given orally.¹⁸ The relationship between the frequency of use of drugs in children in general and allergic as well as poorly understood nonspecific "side reactions" (such as vomiting, diarrhea, and excitation) to these drugs is pointed out in Table II.¹⁹ Of the 280 allergic children in that study who had received injections of penicillin, ten per cent had allergic reactions to this drug. It is to be recalled that spontaneous sensitivity²⁰ to penicillin may fol-

TABLE II
PERCENTAGE OF INCIDENCE OF ALLERGIC AND "SIDE EFFECTS" TO DRUGS IN 500 ALLERGIC AND
NONALLERGIC CHILDREN

	INCIDENCE OF ALLERGIC REACTIONS			INCIDENCE OF "SIDE REACTIONS"*			NO. OF PATIENTS USING DRUG
	IN ALLERGIC CHILDREN	IN NON- ALLERGIC CHILDREN	OVERALL INCIDENCE	IN ALLERGIC CHILDREN	IN NON- ALLERGIC CHILDREN	OVERALL INCIDENCE	
Penicillin	10.0	—	6.8	2.1	—	1.4	411
Sulfonamides	6.7	4.7	6.1	7.7	2.3	6.2	292
Aurcomycin	3.7	—	3.3	17.2	—	14.0	208
Terramycin	3.4	—	2.6	10.2	8.3	9.8	112
Benadryl	2.2	—	2.1	11.3	—	10.7	140
Atropin	2.0	—	1.5	8.3	—	6.2	150
Aspirin	1.9	—	1.3	2.3	0.7	1.7	188
Pyribenzamine	1.7	—	1.6	14.2	—	13.3	231
Codeine	1.5	—	1.3	3.6	—	3.0	260
Phenobarbital	—	—	—	13.0	1.5	9.6	
Ephedrine	—	—	—	7.3	—	6.3	
Aminophyllin	—	—	—	11.5	—	11.2	
Epinephrine	—	—	—	3.0	—	2.6	
Totals	20.0	2.4	12.8	36.0	3.5	25.0	

*Diarrhea, vomiting, exatation

low fungus infections of the skin. Hence, another reason for emphasizing the establishment of good foot hygiene habits in early childhood. It must also be recalled that Salk polio vaccine in present form contains 200 units of aqueous penicillin per cubic centimeter. Another source of drug sensitization which is preventable is contact sensitization of the mucous membranes and skin with "caine" local anesthetic solutions and ointments as well as those containing mercury, silver, antibiotics and even antihistamines. Unfortunately skin testing is of little value in determining sensitivity to most drugs including penicillin.¹⁸ Diagnosis depends on a history of previous reactions. A positive skin reaction to penicillin probably indicates sensitivity, but a negative reaction does not mean lack of sensitivity. There is no correlation between positive skin reactions to penicillin and to the penicillium molds. Finally, in young adults there have been reported instances that despite a negative intradermal test to aqueous penicillin, fatal anaphylactic shock followed a subsequent injection of aqueous penicillin. Although indications for removal of diseased tonsils, adenoids or polyps should be the same as for non-allergic children, "none except emergency operative procedures should be carried out in the nose and throat during the seasons of grass and weed pollination, because of the marked tendency of these children to pollen asthma after such operations."¹⁶

OTHER GENERAL CONSIDERATIONS

Some knowledge of the effect of various types of infection upon a potentially allergic child serves to impress one with the need for doing all he can to prevent these diseases. The pattern of the effect of infections on existing or latent allergies may be of two types. One type of response is observed in association with infections of virus origin, such as measles, chickenpox, mumps, roseola infantum, and the various unidentifiable epidemic virus infections.²¹ During the prodromata of such infections, the allergic response in general is somewhat more exaggerated. During the exanthem or height of the disease, the allergic response is suppressed. This is perhaps best exemplified by a temporary reversal of a previously positive tuberculin²² or by the child who normally develops asthma with each respiratory infection. Such a child just prior to the appearance of Koplik spots has fever and incessant coughing, yet wheezing is conspicuously absent. This combination of events should always suggest an incipient virus infection. During the convalescent period the child has either an exacerbation of his previous allergic symptoms, or has either more pronounced symptoms or has asthma, perennial allergic rhinitis, or hay fever for the first time in his life. Hence, the importance of preventing or modifying measles with gamma globulin where possible. This simple procedure may greatly influence how early

in life or to what degree an infant or child will be afflicted with these allergic phenomena.

The second pattern of response is observed most commonly in association with acute bacterial infections of the upper respiratory tract. With these there is no apparent change in the degree of the allergy during the period of invasion, but at the height of the infection there is an aggravation of the allergy.

Since many infants begin their respiratory allergy following pertussis, early and sustained immunization against this disease is especially important in potentially allergic children.

Sensitization to serum may result from (1) injection of the serum as a specific antisera (because active immunization was not maintained, e.g., tetanus), (2) inhalation of dander,²³ or (3) eating the meat of horse, rabbit or cow.

Since contact sensitization with oleoresins of many plants (especially poison ivy, oak and sumac) may become a problem in both potentially allergic children and those with no family history of allergy, early recognition and treatment of the condition is imperative. Exposed areas of skin may be protected with various commercially available ointments such as Kerodex. Lotions and ointments with zirconium are said to specifically neutralize the toxin of poison ivy, oak and sumac. Prevention or recurrence may be accomplished by hyposensitization with injections of extracts of the specific antigen, but the author prefers oral hyposensitization with varying dilutions of the oleoresins of the specific plant which on patch testing proves to be the etiologic agent.

Finally, in the broad spectrum of prophylaxis of chronic respiratory or dermatologic allergies lies the question of who should receive allergic skin testing? The author recommends complete skin testing in the following situations: (1) atopic dermatitis in children over six months' of age which does respond dramatically to elimination diets and local therapy; (2) bronchial asthma beyond the age of six months of age which does not respond to dietary eliminations alone; (3) pollenosis ("hay fever") which recurs a second season (because of the tendency to develop asthma if pollenosis is untreated); (4) perennial allergic rhinitis which either persists for more than two years or which is associated with recurrent ear infection, despite an adenoidectomy in a non-pollinating season, or with nasal polyps; (5) chronic urticaria. Partial skin testing is indicated in the fol-

lowing situations: (1) contact dermatitis (patch testing only), (2) serum sickness-like reactions to insect bites²⁴ (insect venoms only).

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CANCER OF THE BREAST AT HARTFORD HOSPITAL

PEYTON H. MEAD, M.D., *Hartford*

THE current literature pertaining to the treatment of carcinoma of the breast is voluminous and contradictory. In order to determine the efficacy of radical mastectomy at this hospital, all primary admissions for carcinoma of the breast during the years 1940-1950, inclusive, have been studied. The results have been compared with both the experience here in the preceding years,¹ and with that at Presbyterian Hospital, New York City, during the years 1935-1942.² All secondary cases referred from other hospitals after previous treatment are excluded.

The material was accumulated by review of the hospital Tumor Clinic records, which are abstracted from various sources, including hospital admissions, radiotherapy records, pathological reports, clinic follow-up records, files of private physicians, personal communications from patients or relatives, and occasionally the County Recorder of Vital Statistics or the City Registry. Responsibility for this recording and tabulation of data was not delegated because it was felt that the interpretation of pathological reports, cause of death, and other doubtful aspects required medical orientation.

Tables I and II show that in the State of Connecticut³ breast is the second most common site for carcinoma in females and that the incidence increases steadily with age. The five year survival is 40.7 per cent in all cases (including those diagnosed from death certificates only), but is 46.2 per cent in those cases reported by hospitals (94 per cent of which are microscopically confirmed).

Table III enumerates the presenting symptoms, often multiple, at the time of admission to this hospital. Fifty-one patients were admitted for other causes, at which time carcinoma was detected on routine examination. Tumor was the most common complaint, with pain second. In many instances

The Author. *Assistant Resident, Department of Surgery, Hartford Hospital, Hartford, Connecticut*

SUMMARY

Eight hundred thirty-six primary admissions for carcinoma of the breast at Hartford Hospital, 1940-1950, are reviewed and compared with other series.

The difficulties in interpretation of such statistical data are discussed.

The operability rate was found to be 77 per cent.

The relative five year cure and survival rates were 40 per cent and 49 per cent; the corresponding absolute rates were 35 per cent and 43 per cent, respectively.

Axillary spread was found to have occurred in 55 per cent of radical mastectomies; the incidence was proportional to the delay in treatment and was associated with a 40 per cent poorer prognosis for cure and 20 per cent increased incidence of local recurrence.

No correlation was found between age group and results.

TABLE I
STATE OF CONNECTICUT

I. Age adjusted cancer incidence, in females per 100,000 population 1951	
All sites	250
GI tract	64
Breast	59
Genital organs	55
Skin	24
II. Age incidence per 100,000 population: carcinoma of female breast 1947-1951	
Increases steadily from 0.3 at age 15-19 to 454 at over 85	

TABLE II

STATE OF CONNECTICUT

CARCINOMA OF THE BREAST 1947-1951

I. Total cases diagnosed — 3,243
10.6 per cent from death certificates only
40.7 per cent five-year survival
II. Cases reported by hospitals — 2,898
94.0 per cent microscopic diagnosis
43.7 per cent localized
45.7 per cent regional metastases
6.3 per cent remote metastases
46.2 per cent five year survival

these symptoms were ignored by the patient or by her physician, osteopath, chiropractor, naturopath, or reader, who prescribed heat, massage, poultices, salves, ointments, hormones, or antibiotics for varying periods until the diagnosis became obvious.

TABLE III

PRESENTING SYMPTOMS OF PRIMARY CASES

Manner of diagnosis not stated.....	2
Discovered on routine examination.....	51

BREAST SYMPTOMS

Tumor	714
Nipple erosion	9
Nipple retraction	36
Nipple discharge	31
Nipple itching or burning.....	7
Pain	142
Enlargement	13
Red skin	22
Generalized hardness	9
Shrinkage	2
Trauma	17
Ulceration	25
Tenderness	45
Axillary mass	28
Swelling of arm.....	7
Pain in axilla or arm.....	21
Retraction	1

Table IV outlines the initial disposition of the 836 primary admissions, some of whom were subjected to supplementary surgery at a later date and many of whom were given subsequent palliative endocrine or radiation therapy. The reasons for withholding radical mastectomy in 23 per cent are listed in Table V. The operability rate should increase in the future with early diagnosis and advances in the management of associated chronic diseases. Those carcinomas mistaken for benign lesions were predominantly associated with omitted or equivocal frozen sections.

TABLE IV

Total primary admissions.....	836
Private	675
Ward	161

DISPOSITION

Radical mastectomy	645
Simple mastectomy	73
Simple mastectomy plus axillary dissection.....	18
Excision of tumor.....	3
Radiation only	59
Not treated by radiation or surgery.....	36
Axillary dissection	2

TABLE V

PRIMARY CASES NOT TREATED BY RADICAL MASTECTOMY

Constitutionally inoperable	63
Inoperable because of extent.....	92
Refused	6
Died intercurrent disease.....	4
Referred elsewhere	0
Failed to return.....	1
Carcinoma mistaken for benign lesion.....	7
Not stated	18

Table VI presents the five year results in the 77 per cent of primary admissions subjected to radical mastectomy, as compared to the other two series. These conclusions are summarized in Table VII where in all three series the assumption is made that all cases lost to follow-up or dead of any cause, are dead of carcinoma. The relative rates apply only to radical mastectomies, whereas the absolute rates pertain to the overall results in all primary cases, regardless of treatment, and are more pertinent for comparison with other series.

TABLE VI

FIVE YEAR RESULTS OF RADICAL MASTECTOMY IN PRIMARY CASES

	1940-1950		1932-1939 HAAGENSEN	
	NUMBER	PER CENT	PER CENT	PER CENT
Operative deaths	2	0.3	0.3	1.8
Lost track of.....	49	8.0	3.4	2.8
Died of unknown cause	30	5.0	1.1	1.4
Died of intercurrent disease				
Recurrence or metastases	22	3.0	4.0	3.6
Died from breast carcinoma	200	31.0	45.7	31.1
Alive with recurrence....	57	9.0	3.7	9.5
Alive without recurrence	257	40.0	41.7	49.7
Died with recurrence or metastases	28	4.0	—	—

TABLE VII
FIVE YEAR RESULTS OF RADICAL MASTECTOMY IN PRIMARY CASES

	1940-1950 PER CENT	1932-1939 PER CENT	HAAGENSEN PER CENT
Relative 5 year clinical cure rate	40	41.7	49.7
Relative 5 year survival rate.....	49	45.4	59.2
Absolute cure rate.....	34.6	33.8	39.4
Absolute survival rate.....	43	40.0	47.9

As previously implied, the 8 per cent of patients lost to follow-up have an adverse effect on the results, and this is perhaps partially responsible for the fact that no improvement over our previous experience is seen. Moreover, there is a discrepancy of 10 per cent and 5 per cent, respectively, in the relative and absolute rates as compared to those at Presbyterian Hospital. McWhirter, utilizing partial mastectomy and radiotherapy, quotes a 42 per cent absolute five year survival rate,³ which compares favorably with ours and with other series¹ where radical mastectomy was the chief form of treatment, although it falls short of the Presbyterian results by 6 per cent.

The nine patients who would be classified as inoperable by the Haagensen-Stout criteria (Table VIII) but who, nevertheless, underwent radical surgery (Table IX) corroborate the validity of the criteria. It is to be noted that these investigators no longer consider pregnancy or lactation contraindications to radical mastectomy. In this series there were eight patients in this category, five of whom were subjected to radical surgery, and of those, two are still alive without manifest disease. One of these cases was a Paget's carcinoma without axillary involvement; the other was found to have axillary metastases. Three more were treated with either radiation or simple mastectomy, all of whom died in under five years.

The stated duration of disease on admission correlated well with the incidence of histologically-proven axillary metastases, which were 10 per cent more frequent in those who delayed longest (Table X). Tables XI and XII illustrate the prognostic importance of proven axillary involvement. Fifty five per cent demonstrated axillary metastasis, which was associated with a 40 per cent poorer prognosis for cure and a 20 per cent increased chance of local recurrence in all three series. "Extensive Involvement" is an arbitrary classification including those cases with most nodes grossly and/or microscopic-

TABLE VIII
HAAGENSEN-STOUT CRITERIA OF INOPERABILITY

1. Extensive breast skin edema (more than one third)
2. Satellite breast skin nodules
3. Inflammatory carcinoma
4. Parasternal tumor nodules
5. Proved supraclavicular metastases
6. Arm edema
7. Distant metastases
8. Any two or more "grave signs"
 - a. Skin ulceration
 - b. Limited breast skin edema
 - c. Solid fixation to chest wall
 - d. Axillary lymph nodes 2.5 cm. in diameter
 - e. Fixation of axillary lymph nodes to skin or deep structures

TABLE IX
RESULTS OF RADICAL MASTECTOMY IN "INOPERABLE" CASES

	NUMBER	5 YEAR LOCAL RECURRENCE	5 YEAR CURE
Extensive edema	3	0	0
Arm edema	1	0	0
Distant metastases	2	1	0
Combination of 2 or more "grave signs"			
Ulceration and limited edema	1	0	0
Ulceration and axillary nodes			
2.5 cm.	1	0	0
Axillary nodes 2.5 cm. and fixed	1	?	?

TABLE X
RELATION OF DURATION OF DISEASE ON ADMISSION TO THE PRESENCE OF AXILLARY METASTASES

	1940-1950 NUMBER	1932-1939 PER CENT	PER CENT
Less than one month.....	208	51	51
One—five months	232	56	70
Six or more months.....	174	61	64
Not stated	31	45	60

TABLE XI
RESULTS OF RADICAL MASTECTOMY ACCORDING TO AXILLARY INVOLVEMENT
5 YEAR CLINICAL CURE

	1940-1950 NUMBER	1932-1939 PER CENT	HAAGENSEN PER CENT
Limited to breast.....	286	64	69
Axilla involved	359	20	25
Extensive nodal involve- ment	171	12	—

(16 per cent of those with extensive nodal involvement died in less than one year.)

ally almost completely replaced. The Haagensen figures cited in Table XI refer in this instance to his personal series of patients, and the greatly superior results might be attributed to more careful selection, although his incidence of histologically involved axillary nodes is identical to ours.

TABLE XII

RESULTS OF RADICAL MASTECTOMY ACCORDING TO AXILLARY INVOLVEMENT
5 YEAR LOCAL RECURRENCE

	1940-1950		1932-1939		HAAGENSEN
	NUMBER	PER CENT	PER CENT	PER CENT	
Limited to breast.....	286	5	6	2.6	
Axilla involved	359	24	19	19.3	
Extensive nodal involvement	171	29	—	—	

The age of the patient at the time of her first hospitalization had no predictable or consistent effect on the results of radical mastectomy (Tables XIII and XIV). Neither of the Hartford Hospital series corroborate Haagensen's finding of a more favorable prognosis in the age group over 70.

TABLE XIII

RESULTS OF RADICAL MASTECTOMY ACCORDING TO AGE GROUPS
5 YEAR CLINICAL CURE

	1940-1950		1932-1939		HAAGENSEN
	NUMBER	PER CENT	PER CENT	PER CENT	
Under 30	8	50	25	33.3	
30-34	19	42	10	37.5	
35-39	39	31	39.1	39.2	
40-44	71	37	46.6	42.9	
45-49	83	45	42.5	41.7	
50-54	101	39	36.2	48.3	
55-59	100	39	44.8	38	
60-64	85	45	47.8	33.9	
65-69	63	43	44.1	48.5	
Over 70	76	35	40	57.1	

Since the value of statistics is entirely dependent on their accuracy and completeness, it is interesting to note the difficulties encountered in the evaluation of certain aspects of this disease.

A primary consideration is the inevitable loss of pertinent facts during their transfer from other sources to the tumor records. Other obvious deficits include the patients' indecisiveness or ignorance concerning the onset of symptoms as well as the failure on the part of some physicians to state the exact site, character, and supplementary signs of the

TABLE XIV

RESULTS OF RADICAL MASTECTOMY ACCORDING TO AGE GROUPS
5 YEAR RECURRENCE

	1940-1950		1932-1939		HAAGENSEN
	NUMBER	PER CENT	PER CENT	PER CENT	
Under 30	8	13	50	20.8	
30-34	19	11	30	20.8	
35-39	39	18	21.7	24.2	
40-44	71	16	11.1	21.2	
45-49	83	18	17	19.1	
50-54	101	20	13.7	15.7	
55-59	100	14	14.2	17.5	
60-64	85	16	13	20.2	
65-69	63	13	6.9	10.3	
Over 70	76	10	16	8.2	

carcinoma, or the size, fixation, or even presence of palpable axillary lymph nodes. Supraclavicular nodes were rarely mentioned and even less commonly biopsied. Pre- or immediate postoperative metastatic series were the exception. In some cases denied radical mastectomy, a definite differentiation between inoperability on constitutional and neoplastic grounds was not made. These multiple factors made evaluation of clinical operability difficult in some instances, and undoubtedly a larger number of cases were clinically far advanced than it appeared, although the operability rate of 77 per cent is comparable to the Presbyterian rate of 74 per cent.

The objectivity of the earlier data was affected by the practice of leaving to speculation the quantitative nodal involvement on pathological examination. The quality of follow-up was variable depending on the particular physician's interest in the problem, and the information derived from death certificates in the absence of the postmortem examination was inconclusive in some instances because of insufficient data concerning the antemortem course.

In the tabulation of data related to various factors such as age or duration of disease, smaller samples render the conclusions statistically less significant and further error is introduced in the form of inclusion of relatively larger numbers of unusual pathological or histological types of carcinoma in any one category.

Difficulties inherent in the study of carcinoma of this particular organ, as is well known, include its unpredictable behavior, especially after palliative radiation or hormonal therapy, resulting in not a few deaths due to carcinoma after five or even ten years. There is also the difficulty in differentiating a sub-

sequent contralateral primary carcinoma from a metastasis of the original primary.

This reiteration of obvious inadequacies is applicable to a variable degree in all statistical studies and is included as a reminder that intelligent interpretation is important even in the evaluation of ostensibly objective figures. Accordingly, this presentation of data has been limited to that which seems most consistent with the accuracy of the source material.

Mention should be made of the practices of certain authors, who "adjust" their results according to life expectancy tables, limit their study to particular groups in order to eliminate unfavorable variables, or assume that all cases lost to follow-up are cured. Although the results are inevitably improved by such adjustments, they seem only to

confuse the issue and preclude adequate comparison of various methods of therapy.

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INTRACTABLE POSTINFARCTION SHOCK COMPLICATED BY PULMONARY EDEMA

FRED F. TIRELLA, M.D., *Bristol*

The Author. *Cardiologist, Bristol Hospital, Bristol, Connecticut*

SUMMARY

A detailed account is presented of a 54 year old man who suffered a posterior myocardial infarction followed by intractable shock which persisted for five days before he expired. A severe attack of pulmonary edema complicated the shock, but this was quickly and adequately controlled. Ninety-four ampoules of l-arterenol and 1150 mg. of Neo-synephrine, in addition to 15 liters of fluids with various electrolytes, were used to sustain the patient during the five days following the onset of the vascular collapse, and his death on the fifth day was presumably precipitated by a pulmonary complication.

SHOCK consequent to myocardial infarction may be quite easy to treat or may prove to be intractable. It may occur in reversible or irreversible form, complicated or uncomplicated by pulmonary edema. The mortality of those patients who manifest severe shock approaches 80 per cent. When shock and pulmonary edema are present simultaneously, the mortality rate is even greater. The difficulty lies in the fact that the treatment of shock is in many respects opposed to that of pulmonary edema.

The present report is that of a man who survived a very severe attack of pulmonary edema complicating intractable shock and was kept alive for five days by the use of heroic doses of l-arterenol (Levophed). It also illustrates the difficulty in identifying the so-called "good risk" cases at the onset of a myocardial infarction.

The mechanism of shock accompanying or fol-

lowing myocardial infarction is obscure, and present therapy is empirical. One must depend upon the use of plasma, fluids, blood and stimulants such as hydroxy-amphetamine (Paredrene), phenylephrine (Neo-synephrine), methoxamine (Vasoxyl), mephentermine (Wyamine) sulphate, and l-arterenal. These measures, properly used, may prove highly effective in the treatment of shock. However, failures may occur unless these agents are employed properly. Neo-synephrine and l-arterenal will suffice in most instances of critical shock; Neo-synephrine when it is impossible to use the intravenous route, and l-arterenal when venotherapy is possible. Both may be continued, if necessary, for days, and much larger doses of the latter can be used than was formerly thought possible. The following case illustrates this.

Mr. A.B., age 54, was admitted to the hospital on the morning of August 8, 1956, complaining of severe anterior chest pains, retrosternal in location, constricting in character, and radiating down both arms. He was very pale, was bathed in cold sweat, and he vomited profusely. The heart rate was 50, the heart tones poor, and the blood pressure was 160/90 upon admission. Several injections of meperidine Hcl. (Demerol) were given immediately with no relief, but pantopon gave some. His vomiting stopped after administration of 25 mg. of chlorpromazine (Thorazine) intramuscularly. An electrocardiogram showed the characteristic signs of early posterior myocardial infarction with elevation of the S-T segments in leads 2, 3, and VF. The leucocyte count was 9,200. He received 900 mg. of Tromexan, was placed in an oxygen tent, and was given 3 mg. of Neo-synephrine every two hours for four doses to maintain his blood pressure, since this became lower shortly after admission.

By the next day (August 9) he seemed better. Vomiting had ceased. The leucocyte count was 14,000, Cutler sedimentation rate was 21 mm. in one hour, and the serum cholesterol was 176 mg. per cent. The heart sounds were better and pulse stronger. The blood pressure was 120/80. His electrocardiogram showed the characteristic evolution of posterior myocardial infarction.

On August 11 the temperature rose to 102, presumably from myocardial necrosis. He complained of severe pain in the retrosternal region, requiring the use of pantopon. The blood pressure dropped to 80/60. He received Neo-synephrine, 3 mg. subcutaneously every two hours, but after several hours the systolic blood pressure was below 80 mm. An intravenous infusion, consisting of 500 cc. of glucose in water and two ampoules of l-arterenal, was started.

On August 12 he received an infusion of 1000 cc. of glucose in saline containing three ampoules of l-arterenal and 5 mg. of Neo-synephrine. This was administered through a polyethylene venous catheter. Three ampoules of l-arterenal were used instead of the usual dose of one

to the liter of glucose, because it was desirable to maintain the blood pressure with as little fluid as possible to prevent the onset of pulmonary edema. Saline was given without fear for he had not only lost much gastric content, but also sweated profusely and had gone almost entirely without food since admission. Subsequent infusions, however, consisted of l-arterenal added to glucose in water. When the temperature rose to 102 degrees F. (rectally), he received 200 mg. of tetracycline hydrochloride (Tetracyclon) intramuscularly every six hours, even though the fever was presumably due to the cardiac necrosis. Later that day the systolic blood pressure was below 80, and it was necessary to add one more ampoule of l-arterenal and 10 mg. of Neo-synephrine to the solution in order to maintain the blood pressure between 90 and 100 systolic. He became disoriented and extremely restless, so sedatives were administered freely.

About 9 P. M. on August 12 he developed severe pulmonary edema. The mouth and nose were filled with blood-tinged foam, and the respirations were labored. The skin was clammy, the blood pressure was 50/40, and the lips and nail beds were extremely cyanotic. The infusion was immediately stopped, and 0.33 mg. of strophanthin K was injected intravenously, followed by 2 cc. of Mercurhydrin intravenously. Tourniquets were applied to all extremities, and the patient was placed in a sitting position over the side of the bed, inhaling oxygen through alcohol vapor. Crystodigin, 0.6 mg., was given intramuscularly to complement the half dose of strophanthin. A second dose of 0.6 mg. was given eight hours later. Thereafter he was maintained on 0.2 mg. of Crystodigin daily.

It was believed that although the shock was serious, the pulmonary edema was even more threatening. Consequently, he was treated as though shock were not present. After 30 to 45 minutes the pulmonary edema was under control, but the blood pressure could not be determined and the pulse was no longer palpable. The apical heart rate was about 140, and the sounds were almost inaudible. The head of the bed was lowered to a horizontal position, tourniquets were released, and 4 mg. of Neo-synephrine were injected intravenously. His arm was raised so that the stimulant could flow down by gravity since he had no effective blood pressure. When there was no response to this dose, 10 mg. of Neo-synephrine were injected intravenously, and when that failed, 20 mg. were injected similarly. When there was no response to this, the case appeared to be hopeless. Fifty mg. of Neo-synephrine were injected intravenously, and the arm again was raised so that the drug would flow down by gravity. Soon the blood pressure rose to about 60/50 mm. but declined after about 15 minutes. The pulse was imperceptible. The heart rate at the apex was 140-150. Again 40 mg. of Neo-synephrine and 7½ grains of caffeine sodium benzoate were injected together intravenously in similar fashion. Once more the blood pressure returned, reaching a systolic pressure of 40-60 mm. for a short time. Then he received an intravenous infusion of 500 cc. of glucose in water containing six ampoules of l-arterenal and two ampoules of Neo-synephrine. At 1:30 A. M. his blood pressure was 30/0 and gradually rose so that by 7:00 A. M. it was 80/65. He looked a little better.

On the 13th his temperature rose from 102° to 104° F. The breathing was faster. Signs of consolidation appeared over the right lower lung posteriorly. Whatever the lesion, it added to the gravity of the situation and made the shock more intractable. The dose of Tetracycline was increased to 300 mg. i.m. every six hours. On the 14th his condition was precarious and shock developed if the solution of l-arteronal were slowed down; the blood pressure determined the rate of the infusion. Ever since the night of the 12th Neo-synephrine had been continued in a dose of 5 mg. every half hour intravenously via the infusion tube, depending on the blood pressure. The constant half-hourly administrations of this drug seemed just as important for the maintenance of the blood pressure as was the continuous infusion of l-arteronal. If either drug were decreased or omitted, there was an immediate and precipitous drop in pressure with imminent collapse. Six ampoules of nor-epinephrine were now being added to each 500 cc. of glucose in distilled water.

Since he had taken no nourishment, the diluent for nor-epinephrine solution was changed on the 14th to protein hydrolysate. Seventy-five mg. of sodium heparin were added to an infusion every eight hours in an attempt to protect the patient not only against the cardiac thrombus and possible pulmonary emboli, but also against possible thrombi that might have developed anywhere in his circulation as a result of his going in and out of shock.¹ Twenty mg. of ACTH were given twice daily under the presumption that the pressor effect of levo-arterenol might be potentiated even though there are, as yet, no available clinical data to permit definite conclusions regarding the clinical effectiveness of this agent in association with levo-arterenol.² Beroeca-C had been added to the infusions because of the possible salutary effect of vitamin B upon the heart muscle. Forty m.Eg. of potassium chloride were added daily to the infusions.

On the morning of the 15th he developed generalized body twitches which were immediately responsive to 10 cc. of calcium chloride that were added to the elysis. Some time later he became violent again and tore the polyethylene catheter from the vein. It was several hours before the surgeon could reinsert it, and shortly after the catheter was pulled out, the patient had gone into complete vascular collapse. An intramuscular elysis containing seven ampoules (70 mg.) of Neo-synephrine in 500 cc. of glucose in distilled water was given intramuscularly with Wydase injected at the site of the needle. Another similar dose of Neo-synephrine was given before the surgeon reinserted the polyethylene tubing. At this time 500 cc. of whole blood was administered with three ampoules of l-arteronal.

On the 16th he looked much better and his blood pressure and pulse were maintained more easily. The Neo-synephrine was reduced to 3 mg. every half hour intravenously via the intravenous catheter, and the l-arteronal was reduced to three ampoules per 500 cc. flask of protein hydrolysate. On the 17th his temperature reached 104° F. Signs of consolidation in the chest increased. The pulse became thready in the afternoon (the rate 140), the blood pressure dropped, his respirations rose to 48 per minute, and he died at 9:00 P. M.

Levophed is available in ampoules containing 4 cc. of 1/1000 solution; when added to 1000 cc. of isotonic sodium chloride solution, each cc. of this dilution will contain 4 micrograms of Levophed (as bitartrate). This solution must be given intravenously. If the needle should come out of the vein, resulting in extravascular infiltration, severe ulceration may develop. For that reason it is safer to use an intravenous polyethylene catheter in treating severe shock which may necessitate repeated infusions of l-arteronal for several days. Arteronal does not increase the cardiac rate or the cardiac work—a distinct advantage in the treatment of post-infarction shock. Moreover, it is of value in shock complicating myocardial infarction because it is a coronary dilator.³

Levophed is an irritating drug; consequently, it is best given in the dilution of one or two vials per liter of glucose in water or glucose in saline. If moderately stronger concentrations of the drug are infused, phlebitis may result, and with increasing concentration, sloughing and even gangrene may develop, particularly if the leg veins are used in elderly or diabetic individuals. The use of a polyethylene catheter, inserted high into the lumen of a vein, does not guarantee against paravenous infiltration and ischemia, for extravasation at the site of the infusion is not the only cause of damage. It has been suggested that the vasa vasorum of the vein wall may become constricted, interfering with the physiology of the vein wall and resulting in some leakage along the course of the vein. Hence, not only should the drug be well diluted, but also a femoral or antecubital vein should be used.

In the case presented, high concentrations were used because the usual dilution would have necessitated the administration of large amounts of fluid. This was contraindicated by the constant threat of pulmonary edema. Even stronger concentrations were apparently indicated but were avoided by the persistent use of large doses of Neo-synephrine. It would have been impossible, otherwise, to obtain the desired pressor effect with Levophed alone, for higher concentrations certainly would have resulted in damage greater than the benign phlebitis evidenced. At no time did the nor-epinephrine ever raise the blood pressure to levels over 150 systolic, and no ill effects could be ascribed to the doses used.

Ninety-four ampoules of Levophed, 1150 mg. of Neo-synephrine, and 15 liters of fluid were used in

the five day period of shock. Friedberg¹ recommends using one to four ampoules of Levophed in 1000 cc. of glucose solution, and if there is no response, higher doses may be tried for as long as necessary. Rheinlander, Kaplan, and Etsten cite a patient with shock who received 1300 mg. of Neo-syneprine hydrochloride in 2650 cc. of 5 per cent dextrose in water in one 24 hour period. Another received 2539 mg. of the drug over a six day period.⁵ Siglin used 16 mg. of l-arterenal per liter of 5 per cent dextrose in water continuously for 14 days in a case of postinfarction shock.⁶

The case presented illustrates the value of both Neo-syneprine and l-arterenal, the pressor actions of which are similar, in combatting postinfarction shock. Usually l-arterenal alone is quite adequate to combat most cases of shock that will respond to therapeutic stimulation.

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RESERPINE THERAPY PRODUCING MASSIVE GASTRIC AND DUODENAL HEMORRHAGE

ALFRED T. ST. JAMES, M.D., and ALLAN J. RYAN, M.D.

RESERPINE is a new and potent weapon in the physicians' armamentarium and as such has proven some great benefit in the struggle against hypertension and certain disturbed emotional states. It is, however, a two-edged sword as has recently been pointed out by several authors. It is with its effect on the upper gastrointestinal tract that this report concerns itself.

Reserpine given either parenterally or orally produces an increase in total gastric secretion and free hydrochloric acid. This has been demonstrated experimentally by many authors including Haverback *et al.*¹ These same authors also report a case of their own of a 42 year old hypertensive patient who developed abdominal cramps and melena while on reserpine. The bleeding ceased when the medication was stopped and subsequent investigation failed to reveal any cause for the bleeding. This is of interest in the light of our own experience and will be discussed later on. Schroeder and Perry² reported recurrence of peptic ulcer with bleeding in three patients, one of whom required gastric resection for perforation. Hussar and Bruno³ report three cases of acute duodenal ulcer associated with reserpine ther-

Dr. St. James. *Associate Senior Attending Surgeon, Meriden Hospital, Meriden, Connecticut*

Dr. Ryan. *Senior Attending Surgeon, Meriden Hospital, Meriden, Connecticut*

SUMMARY

A case of multiple superficial gastric and a duodenal ulcer with massive hemorrhage while under reserpine therapy is presented. The superficial nature of the ulceration is emphasized, also the effect of reserpine on gastric secretion. A plea is made for caution in the use of reserpine in patients with an ulcer history.

apy; none of these patients had a history of previous ulcer and none had bleeding.

CASE REPORT

A 71 year old housewife was admitted to the Meriden Hospital on September 10, 1956 with a complaint of vomiting blood. On the night before admission she complained of lower abdominal pain which was moderately severe and only partially relieved by taking Bufferin. The next morning she was nauseated and vomited a small amount of what appeared to be mucus on several occasions. In the afternoon,

after taking tea and broth, she vomited coffee-ground material, and in the early evening after taking a small amount of tea vomited frank blood.

As a young woman she suffered from mild, chronic indigestion but a specific diagnosis was never made. X-rays of the colon one year ago showed diverticulosis. She had never had any previous operations. She has three living children. She has been known to have moderate hypertension for about seven years. Four years ago she suffered a cerebral accident, which impaired her mental faculties and coordination but did not result in paralysis. For the past two years she has been taking reserpine in the form of the powdered whole root and in a dose of 100 mg. twice daily. This exerted a moderately favorable effect on her blood pressure. It also appeared to accentuate mental depression.

Physical examination on admission showed a well developed, well nourished, elderly white female, who was mentally confused. There was some pallor of the skin and mucous membranes. Heart rate regular, sounds good. Blood pressure 180/100. The abdomen was not distended. There was some epigastric tenderness. Rectal examination showed some grossly brown stool.

Shortly after arrival in the hospital she vomited about 500 cc. of bright red blood. An emergency G.I. series was performed which showed a picture suggestive of duodenal ulcer. There was no evidence of hepatic or splenic enlargement nor of esophageal varices. A Levine tube was inserted in the stomach and approximately 1000 cc. of blood evacuated through the tube and by vomiting. She was given 1000 cc. of whole blood by transfusion. There was no further gross bleeding, although the stomach drainage continued to be blood tinged for twenty-four hours, and stools were tarry black. On September 12 a second G.I. series was obtained which confirmed the findings of the first. On September 13 operation was performed. The stomach and duodenum appeared to be grossly normal. When the stomach was opened in the region of the antrum, however, an area of ulceration 0.5 cm. in diameter was found on the anterior wall of the first portion of the duodenum. A partial gastric resection was carried out, removing the distal three quarters of the stomach and creating a gastrojejunostomy anterior to the colon. Pathological examination of the resected specimen revealed multiple areas of superficial ulceration of the gastric mucosa. There was no evidence of a chronic ulcer in either stomach or duodenum. The patient made an uneventful recovery from this procedure

and was discharged in good condition on a convalescent ulcer diet.

Since discharge from the hospital, the patient has never manifested any sign of gastrointestinal bleeding, although she was operated on again November 12 for repair of an incarcerated femoral hernia. She has not resumed the reserpine and blood pressure appears to be stabilized around 180/100 without untoward symptoms.

COMMENT

Gastrointestinal distress, ulcer, and gastrointestinal bleeding without demonstrable cause have all been reported associated with reserpine therapy. As mentioned earlier, it has been adequately demonstrated that reserpine increases gastric secretion and acidity. The pathological findings in the case presented herein consisted of multiple superficial areas of ulceration. These we feel were secondary to a state of hyperacidity. Had the patient's bleeding ceased and had there been even a short delay before x-ray examination, the cause of the bleeding probably would not have been found. This may very well have been the sequence of events in the case reported by Haverback.¹

One should keep in mind the side effects of reserpine, and one should be especially cautious in using this drug in patients who give a history of peptic ulcer. Combining reserpine with other drugs will not prevent complications, since Clark and Wolf as quoted by Hussar and Bruno³ have pointed out that the hyperchlorhydria produced by reserpine cannot be altered in man by the administration of atropine and methantheline bromide (Banthine).

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ON SINGLE-BARRELED COLOSTOMIES

FREDERICK W. ROBERTS, M.D., and NORMA S. FILER, R.N., *New Haven*

ALTHOUGH many people have been able to adjust their lives to a colostomy, to some its presence continues to be a problem. Lack of control, an offensive odor and bleeding from protruding mucous membrane causes dissatisfaction. Recently we have used a new approach to this problem which has been helpful to a number of patients with single-barrel colostomies.

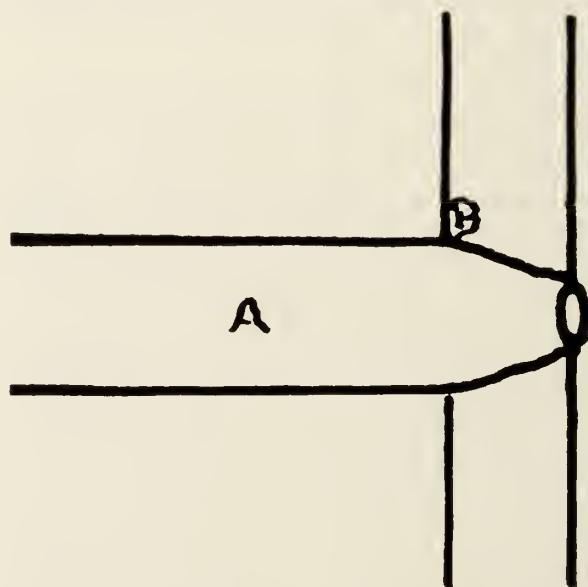
At the time of operation the clamp across the bowel is applied at a level with the skin so that upon removal of the clamp and after trimming the crushed bowel the mucosa heals even with the skin. A few silk sutures, placed properly, are helpful. The opening through the abdominal wall is made so that upon healing the size of the bowel and opening to the outside is about the size of one's little finger.

If the diet is controlled so that a formed stool becomes the normal, area A in the diagram becomes filled and stalls at B in the diagram because of the small opening through the abdominal wall. At night mineral oil or sweet oil is inserted before retiring if constipated and in the morning the contents of (A) is washed away with an irrigation. A gauze pad is placed over the opening and the patient usually goes through the next day without mishap.

There is no objectionable fullness due to a bag, there is practically no odor of secretions from exposed mucous membrane, there is no bleeding, and there is considerable control due to the narrowing of the opening to the outside. One young woman has pointed out that in case she were at a social occasion and felt something coming from the open-

ing, it was easy to control with pressure of the finger until she could reach a rest room.

Objectionable narrowing of the opening due to the overgrowth of scar tissue has not been our experience, and we think this does not occur if the mucous membrane is cleanly sutured to the skin edge in the first place. If it does occur, adjustment



of the size of the opening can easily be accomplished under novocaine. Care should be taken not to make the outlet too small.

The usual protruding colostomy is somewhat analogous to a rectal prolapse. This procedure more nearly conforms to the design of the normal rectum and anus.

SOCIAL WELFARE AND THE M.D.

LAVIUS A. ROBINSON, JR., M.D., *Danielson*

UNFORTUNATELY social legislation and social progress in man's interpersonal relations with man have not made the strides of progress that have been made in technological fields. It is, however, equally fortunate that more thought and insight into the problem has been gained by people in high places than was evidenced by the famous remarks accredited to Marie Antoinette.

The key to any welfare program is: 1. The recognition of need. 2. Knowledge of the available facilities and resources. 3. Administration of the same. The physician plays a very dominant role in this aspect and he should have at his fingertips the knowledge of how to set the wheels in motion when he recognizes bona fide hardship.

It is absurd for any of us to keep details and amounts of aid constantly in the mind, but it is highly important for us to know in our individual communities from whom pertinent information may be obtained quickly and readily concerning these programs.

If you happen to be a physician in a large urban center such as Hartford with its well staffed Welfare Department and have privileges at a hospital which has a well staffed Social Service Department, the individual patient welfare problem is then easy. It is in the more rural areas that it takes resourcefulness and imagination on the part of the physician to care for these people.

CHANGE IN RESPONSIBILITY

Heretofore the responsibility for a community's indigent, both medically and socially, has remained with the members of their respective families or their particular town fathers. In short, the welfare has classically been a provincial thing. The family physician had to solely assume their financial liability if they were to receive any medical care. Bismarck in Germany was the first to recognize the need for social security. This country's first recognition of medical need and social necessity came in the first decade with the Workmen's Compensation

The Author. *Associate in Medicine, Day-Kimball Hospital, Putnam, Connecticut*

SUMMARY

Formerly the responsibility for the medical and social care of the indigent in any community was a local problem. During the last half century there has been a change in the concept of the relationship between the Federal government and the private citizen as it pertains to social welfare. A shift in population is largely responsible for this change.

The physician as a private citizen should keep informed about the expenditures of public funds and exercise his influence and knowledge to further the proper use of welfare services for his patients. The physician should familiarize himself with the major Federal agencies as the Department of Health, Welfare and Education and the Veterans Administration; with the State programs; and with the programs of the local governments and civic agencies. One of the most important programs of welfare aid today is contained in the operation of the Social Security Act which provides for old age assistance.

The medical benefits under the welfare programs are discussed. The program of Aid to Dependent Children is explained. Compulsory health insurance should not be considered until all the States have attempted a welfare aid program similar to the one now in operation in Connecticut. Physicians have an unparalleled opportunity to direct the rehabilitation of the aged and prevent government interference with the private practice of medicine.

Law. Here for the first time medical expenses, liability, and just compensation were given to the laboring man injured in the course of his duty without his employer's recourse to the common law. The Anti-Child Labor Law and Bureau of Children's Services and the advent of Old Age Security

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Insurance and its sweeping ramifications have been followed by a rapid succession of social legislation.

In 1887 Grover Cleveland vetoed relief to drought-stricken farmers in Texas ending his veto message with the following sentence: "It is the function of the people to support the government—not the government to support the people." In 1954 President Eisenhower sent a bill to the Congress entitled "More Security for More People." There are many reasons for this vast change in concept of the executive branch of the government just as has been equally vast a change in what private citizens have come to expect from government.

Probably the most important single factor that has been responsible for this change has been the shift from an agrarian society to an industrial society and from a mostly rural to urban living. The passing of the large roomy farmhouse inhabited simultaneously by many generations where an ancient greatgrandmother was economically important and its replacement by the small three or four room family dwelling unit has produced unwanted grandparents who have no means of support.

It is my first contention that our major responsibility in the field of social welfare represents one as private voting citizens. We should keep ourselves informed about what is being done with public monies and secondly we should use our knowledge of health matters and our position of influence in a community to see that correlative services to our patients are available; for example, helping to start visiting nurses associations where there are none. It makes little sense to hide behind the professional mantle in matters politic and then berate the law when a sound medical regimen cannot be carried out in a welfare patient.

The administration of public welfare is almost as big as the government itself and has a complexity beyond the comprehension of one person. Fortunately, however, most of it is not germane to our present discussion. Organization can be categorized as follows: Federal, State, local government, voluntary organizations and private practitioners.

FEDERAL ORGANIZATIONS

Practically every one of the Federal departments has a direct or indirect role in welfare and health. Of course, the most important government agency is the Department of Health, Welfare and Education. This controls many agencies: The Bureau of Child Health and Maternal Welfare, the Bureau of

Children's Services and many others. I am sure that all of you are very familiar with the public health service and its vast program in direct environmental control through protection of public water supplies and sanitation, its administration of the epidemiological control of diseases, and its system of public health hospitals. Of particular note is its program of research grants and research fellowships which are made directly. It also administers the Hill-Burton Act and the control of aid to hospital construction. For the most part, however, these services are more or less indirect. By far the most important welfare service in the department is its administration of the Old Age Security Insurance Act.

More will be said later on concerning extension of the benefits under this department and some discussion will be given to proposed legislation which will be administered by the Department of Health, Welfare and Education.

The second major agency in the public interest is the Veterans Administration. The government through this channel has shouldered the responsibility of caring for all wounded veterans and has 114,000 hospital beds to implement this program. In most of these hospitals "service-incurred illness" is loosely interpreted and many medical services are available to veterans.

STATE WELFARE ORGANIZATIONS

There is a tremendous variation in the various states' activities in social welfare. For example, the states like Mississippi supplement the governmental programs very little. We are very fortunate to have in Connecticut one of the best State Departments of Welfare. The State also maintains its own public health department and its well known services directly to the physician and to the patient. The State has a program of general assistance and also administers the provisions of the Social Security Act and is partially reimbursed by the Federal government for its activities in Old Age Assistance, Aid to Dependent Children, Aid to the Permanently and Totally Disabled, and Aid to the Blind. In Connecticut the average monthly allotment is \$85.01 as compared to a national average of \$52.

LOCAL AGENCIES

The local agency in Connecticut is the town government. Here there is tremendous variation in programs and facilities varying almost directly with population and need. Functioning at the town, county and State levels are the private practitioners

and their societies. In any welfare program, I am sure you are all familiar with the tremendous amount of free time, free medical care and free medical advice that is given by the medical profession to patients directly in the community, to patients on the ward service in general hospitals, and to the public as a whole through educational programs.

CIVIC AGENCIES

The final component in this vast welfare program is the civic agencies. For the most part these are lay organizations such as the Red Cross, Salvation Army, Infantile Paralysis Foundation, Heart Association, Cerebral Palsy Foundation. There are many other organizations with both real and intangible services such as counseling, family guidance; however, the variation here is tremendous and each individual agency has to be contacted in each locale to determine the amount and kinds of aid.

Starting on the town level with an individual practitioner and an individual case of need, the first source is the general assistance program. This is usually for transients, short-term assistance and people who have not satisfied residence requirements of one year of the State-administered Federal program. The towns pay this aid out of their general tax funds for both direct assistance and medical benefits. This aid is administered by the first selectman or in larger communities by a social welfare officer. The individual towns are reimbursed about 35 per cent from the State general fund for their activities in this sphere.

OLD AGE ASSISTANCE

Beyond the program of general assistance and from which most welfare is obtained is the Old Age Security Insurance Act or in common parlance Social Security. This is an extremely complex program and its total concept is not readily apparent to the casual observer. It was originally intended that through small payments by the worker and his employer, a retirement plan could be instituted. However, many people were already beyond retirement age and there were many others who were sufficiently close to the retirement age that unless the so-called premiums were exorbitantly high the pension would have to be very modest. To fill in this stopgap a temporary program of Old Age Assistance was conceived. It was first intended that as time went on and more people paid premiums over a longer period of time that their pension would

be sufficient to maintain them without additional support from Old Age Assistance. However, as you well know, in its beginning less than half of the working population were covered by the Social Security. The requirement of steady employment and a worker passing from covered to noncovered positions still gives us many workers who receive only small benefits from Social Security and Old Age Assistance has to supplement their pension to maintain a basic standard of living. Of particular importance to us, the Social Security program has no direct medical benefits. In the same law provision was made for aid to dependent children and aid to the blind and more recently in 1951 subsistence aid was made available to the permanently and totally disabled.

Basic to these programs is the means test. This is based on the original concept that a family is responsible for its own members and a father and mother or son and daughter are responsible one to the other. If the one will not voluntarily support the other and are financially able to do so, the State will make an attachment on their income and apportion it to the needy persons. This is done by a budget program and the financial responsibilities of the wage earner to his own immediate family are considered and only after this is the size of his apportionment to his needy relative determined. Therefore, a person might receive income from various sources to make up what is determined as a minimum standard of living. For example, they may have a small income from retained stock or other financial assets as long as the total worth of these assets is not over \$600, a small pension from Social Security, a small apportionment from son or daughter and sufficient money to maintain a minimum standard from Old Age Assistance. The humane part of Connecticut's program is that medical expenses above and beyond this are paid directly from the State without further recourse to the family. In other words, it is assumed that the relative is paying the maximum he can afford and no additional financial hazard is incurred even by catastrophic illness. With the same line of reasoning, expenses of inmates in State-owned institutions are apportioned to members of the family according to their ability to pay. Payments may be less than \$5 per month but at least some effort is made to get relatives to maintain their responsibility to relatives.

There is a notable exception to the \$600 limit on financial assets. This occurs when a needy person

or husband and wife or family unit own their own home at the time that they become financially indigent. If they do not wish to sell their home and live on these assets until they are liquidated, they may keep their home to which the State attaches a first lien and at the time of their death, the administrator of the estate will sell the property and the accumulated benefits paid in allotments will be attached by the State against the estate.

A new law passed by the recent legislature frees grandchildren from responsibility of grandparents and vice versa. In the means test, siblings are not responsible one for the other. Whereas attempts may be made to get voluntary help from siblings for needy relatives, there is no legal coercion. The same provisions hold for all of these four programs.

MEDICAL BENEFITS

The medical benefits under all of these are the same. The patient can go to a doctor of his choice, buy drugs and equipment from vendors of his choice and be admitted to a hospital of his choice. This to me represents a high evolution of social welfare thinking. To be sure the medical assistance is governed by the law that medical care which is necessary and reasonable only will be paid for and not care that is merely desirable or convenient. The program will pay private practitioners according to a fee schedule as determined by the Commission on Finance and Control. This schedule is available to all physicians. Whereas the fees are modest, the physician is assured 100 per cent collection. Wherever possible U.S.P. preparations should be used and the physician must justify the use of any drug by medical case histories and reports of medical examinations. Parenteral vitamins must be justified by clinical data and the same holds for the use of antibiotics. In short, the State medical program insists on the kind of good ethical medicine that was taught to all of us as medical students, using no drugs where no drugs are available and symptomatic treatment that is least harmful and costly.

When a patient is admitted to a hospital, the physician may no longer receive a fee for services. The patient is admitted to the ward service of the hospital, and the ward rate paid to the hospital is determined by the Hospital Cost Commission and varies with the facilities involved.

AID TO DEPENDENT CHILDREN

Of particular note is the program of Aid to Dependent Children. With increased divorce rates and

"enlightened viewpoint towards out-of-wedlock children," case load activity in this sphere will be increased. Many righteous citizens are indignant that the State should make it so easy for wayward girls and their ill conceived offspring, but it is the innocent offspring that is the benefactor of the program. Research in families receiving aid from this program have shown that illegitimacy rates in children born out-of-wedlock on this program are no higher than those in the general population, and the oft repeated credo that illegitimacy will breed illegitimacy has not held true. There is no correlation between the availability of assistance and illegitimacy rates, and the additional allotment for each additional dependent is not sufficient to induce further illegitimacy to raise the monthly allotment.

In comparing the social status obtained by these children of this program, it has definitely been proven that educational attainment and economic independence of these children has greatly improved with today's program of maintaining the integrity of the home than those same children of yesteryear placed in county temporary homes and brought up by foster parents. Aid to the Blind is largely self explanatory. Aid to the Disabled is a relatively new program and not much experience has been gained as yet, but here the physician must be careful in his interpretation of the phrase "permanently and totally disabled."

Application for these programs is made through the local selectmen or welfare officer who is the board of primary review, and he determines whether this is a likely case for assistance. This is in turn referred to the district office and is reviewed by a case worker who determines the validity of the need. Under the original law persons are guaranteed a fair hearing pertaining to their need, and anyone turned down by the previous two agencies has recourse to the State office.

It must be emphasized that the medical aspect of the program was conceived by and is supported by Connecticut's residents. We do receive reimbursement from the Federal government for pensions and living expense allotments given under these programs, but the medical expense is shouldered completely by Connecticut's citizens and is their answer for medical care of their own indigent. To my way of thinking, this is the only logical way to perform this moral responsibility, letting relatives and friends through their own taxes pay for their own needy.

To be sure, there are other groups who when faced with medical expenses are near indigents. For example, many people have assets and private pensions sufficient to maintain their subsistence needs. Hospitalization for even short periods of time sorely overtaxes their resources and if they liquidate their holdings to pay hospital bills and other medical expenses, their subsistence allotments are materially affected, and then they have to apply for State aid. We know that many of these are ward cases and already receive doctors' services free of charge, but they need help in the area of some form of health insurance which they can afford.

COMPULSORY HEALTH INSURANCE

There are those who believe that our present system is inadequate and they speak in flowing terms about the nation's health problem and suggest all sorts of Federal programs to take care of this need. Many bills have been introduced into Congress, as you well know, to have government sponsorship of compulsory health insurance. Failing this, the same group of politicians aiming at that group of increasing number of voters beyond 65 have tried to get medical benefits included in the now existing Old Age Survivors Insurance plan. In short, this would take the medical subsidy out of the State programs and into the general Federal program. There is no doubt that in many States there is an acute need for medical aid to the indigent. But these States have not attempted a program such as ours.

In the *Journal of the American Medical Association* for June 5, 1948 there is a summary of the Brookings report on Compulsory Health Insurance. This is short, direct and to the point and should be read and reread and understood by every one of us. I quote, "The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future as in the past provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired or unendowed, or are widows or deserted women or their dependents. It is doubtful that they could be effectively covered by compulsory health insurance because they would lack the means to attain and maintain an insured status." Former Secretary Hobby estimated after careful consideration by her department that there were about thirty million people in this category. This is the group we have

been talking about and this is the group for which our own State has done an admirable job in offering them medical care.

It is for you and me who are physicians to know what is available to them and to be sure that each of them avail themselves of the public and private facilities to alleviate their suffering.

Those of you who heard Dr. Rusk's brilliant address are already familiar with the immensity of the problem and realize that with increased expectancy and manifest longevity the outlook is for an even greater problem. In 1935 to 1950 the general population increased 18 per cent whereas the population over 65 increased 57 per cent. In the present decade we are certain to be faced with an even larger percentage of our population over 65.

We in the medical profession have been on the firing line and have been the target of much abuse because of our firm convictions against compulsory health insurance and any other governmental interference with the private practice of medicine and we hold inviolate the physician-patient relationship. If we can succeed in doing as Dr. Rusk pointed out, the rehabilitation of the aged and extending the retirement age beyond 65, then it is for us to help industry shoulder its responsibility in finding occupations for these people, such that these no longer twilight years can be productive and useful and not periods of existence on meager subsistence and waiting for the end. I am sure that all of us agree with President Eisenhower in his message to Congress in January, 1954 when he said "No nation and no administration can ever afford to be complacent about the health of its citizens. While continuing to reject government regimentation, we shall with vigor and imagination continually search out by appropriate means, recommend and put into effect new methods of achieving better health for all of our people. We shall not relax in the struggle against disease. The health of our people is the very essence of our vitality, our strength and our progress as a nation."

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EDITORIALS

Thomas P. Murdock, M.D.

The Silent Reaper has again made his presence felt in the lives and hearts of Connecticut physicians. Dr. Thomas P. Murdock passed away at his home on April 1. Tom was a tireless worker for medicine, beloved by his colleagues, not only in Connecticut but across the nation. He contributed much even to the end and his presence will be sorely missed in the meetings of the Board of Trustees of the American Medical Association, the Council of the Connecticut State Medical Society, and many other groups where his forceful character made him a leader.

Two years ago when Tom underwent a serious operation it was hoped that he might be spared for many more years of productive effort on behalf of organized medicine. It was not to be. To carry on the active program required of an AMA trustee necessitated fortitude as well as zeal and a loyalty to a cause. All of these he possessed, serving faithfully under physical handicaps.

Tom Murdock was one of Connecticut's outstanding physicians. The July issue of the JOURNAL will be devoted to testimonials by his friends and to manuscripts from his special field, internal medicine. In this small way it is hoped to record for posterity some of the highlights from the life of this great man.

New Concept for Old

Since the Second World War psychiatry has grown into a highly complex medical discipline with ramifications involving nearly every phase of living. The need for it in our society, reeling back from the cataclysm wrought by our own technology, resulted in the adoption by those concerned with social welfare of some of the principles of the new psychology. So far they have served us well.

However, many functions of "the new psychiatry" are not medical really. This brings in the terms, "social psychiatry" and "medical psychiatry." In the former the physician specializing in mental and emotional disorders supervises supposedly the therapeutic activities of nonmedical personnel. In the latter, patient and physician form a direct and personal relationship for the purpose of treating the ills of this one individual patient. The benefits accruing to the patient's family and community from successful treatment by the physician were not the doctor's primary concern nor should they have been.

In the past three hundred years scientific medicine, meeting the demands of the times, solved or softened problems of the threats to the physical part of man. This part is universally essentially the same.

Gradually the patient came to be considered as existing in a sort of vacuum. Factors extraneous to the proper treatment of physical illnesses could thus be excluded.

This *in vacuo* approach was right for its time and with it medicine reached its highest pinnacles of service to mankind. Further fragmentation of the individual patient came naturally as the complexity of our knowledge demanded specialization and sub-specialization. The "vacuum" grew.

The social consciousness of our era, which Dr. Braceland describes so well in his paper as one of the major forces affecting medicine today, abhors a vacuum. It is no surprise that the chief complaint about medicine at the present moment when it is at its zenith concerns the "coldness" of the doctor toward his patient. This "coldness" is a characteristic of scientific detachment—and bad manners.

Advocating a return to the ways of the "old family doctor" is as impossible as it is ridiculous. He never existed. There were a group of dedicated and probably kindly men who practiced medicine almost solely as an "art" because they could not do otherwise. They did not have the knowledge in their times which we consider fundamental today.

Obviously, we are just as ignorant today of certain aspects of medicine, especially of human "intangibles," as the doctors mentioned above were of, say, the germ theory of disease.

A new knowledge of the social functioning of man is demanded now. The demand is being met as best we can in our times with our "art" until our science relieves it.

Healing Body and Soul

The necessity of ministering to the spiritual as well as to the physical needs of the sick is recognized today more than ever before. This is particularly true in our hospitals which have supplanted the home as an abode for the ill. Dreamed of for several years, a Protestant chaplaincy for the hospitals of Hartford is now a reality through the generosity of Attorney Lewis Fox. The new incumbent, Rev. E. Wendell Stephan, has taken up his duties at Hartford Hospital under the Anna M. Fulling chaplaincy in whose memory it has been named. A housekeeper for 45 years in the Fox home, Miss Fulling possessed grace and goodness, compassion and love which made her a model for the chaplaincy which carries her name. As Dr. Drew, pastor of the Asylum Hill Congregational Church, said at the recent service of recognition, "a chaplaincy of Protestant Christian orientation, endowed by a man

of Jewish faith, attests to the life and work of a true woman of God."

Rev. Stephan comes to Hartford from hospital work in New York and New Jersey. He will work here under direction of the Greater Hartford Council of Churches. In his response at the recent service he said that the hospital chaplaincy "does not mean that the ministry is invading the field of medicine. It does mean," he said, "that an individual's pain, loneliness and fear are not his to be borne alone" but that both the hospital and the church stand ready to help ease the strain.

This is the first such chaplaincy to be established in a general hospital in Connecticut.

Responsibility For the Early Detection of Malignancy

It is obvious that there are two persons responsible for the early detection of malignant growths, the patient and the physician. As to the patient, it is of course necessary to find some means of educating the masses as to the symptoms or signs which should make them suspicious of the possibility of cancer. In this country and many others there are cancer societies which make a point of publicizing through literature and radio the warning signals which should make one suspicious: lumps in the breast or elsewhere, certain skin lesions such as moles, enlarged lymph nodes, unusual discharges from the body apertures, hoarseness, cough, changes in intestinal or urinary habits, etc. The difficulty about this process is that some patients neither read much nor listen much, some procrastinate, even in the face of warning signals, some are indifferent, some are followers of cults which do not believe in the surgical care of disease. As a result many reach the doctor too late.

The role of the physician is to take a careful history of the patient, make a thorough physical examination and arrange for necessary technical tests, such as x-ray, special cytological or chemical examinations of various discharges, biopsies by needle or otherwise, test meals, sputum examinations, etc. He should be guided as to what is needed by the results of his preliminary examinations.

No doubt the results of cooperation or lack of cooperation between patient and physician vary in different civilized countries. In Peru a statistical study of 1,000 patients examined in the outpatient

department of the National Institute of Neoplastic Diseases has recently been reported by Dr. E. Cáceres Graziani, director of the institution.* In this series the patient was entirely responsible for the delay in 4.8 per cent of the cases; both patient and physician were responsible in 12.1 per cent; the physician was solely responsible in 13.6 per cent; and there was no delay in 25.5 per cent. In a word the physician was wholly or partly to blame in 25.7 per cent.

The delay on the part of the physician was sometimes due to inability to reach a diagnosis within a month after seeing the patient, wrong treatment because of mistaken interpretation of the symptoms, incomplete examination of the patient, wrong advice or lack of advice by the doctor, and delay in referring patients who failed to improve under his treatment to a specialist or a cancer clinic. Curiously enough diagnosis was delayed in 93.9 per cent of patients with the most obvious type of malignancy, skin cancer. In cancer of the lips, esophagus, bladder, and vulva, diagnosis was delayed in 100 per cent, while late diagnosis in cancer of the stomach occurred in 54.5 per cent only.

G. B.

*J. A. M. A., 1955, Vol. 158, p. 968.

AMA Plans Outstanding Medical Meeting in June

Physicians attending the AMA's 106th Annual Meeting in New York City June 3-7 will find a star-studded revue of exhibits, scientific lectures, medical films and color television programs lined up for their pleasure and enlightenment. Approximately 18,000 physicians from all over the country are expected to participate in this world famous "short course" in postgraduate medical education. Focal point of the scientific program will be the Coliseum, New York's new exhibition hall, with four floors devoted to technical and scientific exhibits, many of the scientific meetings and the color television program. A number of section meetings plus the scientific film program will be held in hotels near the exhibit hall. Headquarters for the House of Delegates will be the Waldorf Astoria.

An outstanding scientific lecture program is being arranged by the Council on Scientific Assembly. Kicking off the general scientific program on Monday morning, June 3, will be a review of recent progress in surgery while the afternoon session will deal with recent advances in medicine. Tuesday morning's general meeting will feature a discussion on the use and abuse of mood-altering drugs in daily practice.

Formal section meetings will run from Tuesday afternoon through Friday morning. Many of the sections will combine to present special symposiums and panel discussions. The Section on Miscellaneous Topics is arranging sessions on allergy, legal medicine with a mock trial involving the testing of drinking drivers, and methods of improving communication in medicine. A number of exhibit symposiums and question-and-answer conferences also will be held. Special exhibits on fractures, diabetes, perinatal mortality, pulmonary function testing, fresh tissue pathology, arthritis, and nutrition also will be presented.

The color television program presenting live surgical procedures from Roosevelt Hospital will again be sponsored in cooperation with Smith, Kline & French Laboratories.

A foreign air is being added to the regular medical film program for the first time. More than 20 foreign countries are sending special films dealing with many aspects of medical science to the "international medical film program." Both the international and regular film programs will be held at the Barbizon Plaza Hotel.

Registration officially opens at the Coliseum Monday at 8:30 A. M. and closes Friday noon. Advance registrations will be accepted Sunday from 12 noon to 4:00 P. M. The exhibit hall will be open to "doctors only" on Tuesday and Wednesday mornings to give physicians an opportunity to circulate more freely among the technical and scientific exhibits. For your comfort, the new Coliseum has many facilities, including air conditioning, escalators, elevators, a cafeteria, and snack bars.

Physicians and their wives should plan now to attend this worthwhile medical conclave. Further details will be published in the *Journal of the AMA*.

PROGRESS IN CLINICAL MEDICINE

MODERN TRENDS IN PSYCHIATRY

FRANCIS J. BRACELAND, M.D., *Hartford*

The Author. *Psychiatrist in Chief, Institute of Living, Hartford, Connecticut*

SUMMARY

Changes and innovations are occurring in the whole field of psychiatry. They have to do on the one hand with the growing community practice of psychiatry and the integration of psychiatry with medicine, and on the other with attempts to convert mental hospitals into therapeutic communities and centers of education, training and research. Psychiatric treatment is advancing rapidly under the impact of new drugs, expanded programs of psychotherapy, and the application of new insights afforded by social and interpersonal psychiatry. The author discusses these developments, emphasizing at the same time the difficulties of fully exploiting the possibilities of modern psychiatry because of overcrowded, outmoded institutions and shortages of staff and personnel.

are not. This is a recent acceptance, if you please, and I think I have quoted for you elsewhere Strauss' astute observation:

"The modern psychiatrist presents a challenge and the attitude to him is curiously ambivalent; at the same time as he is regarded with a considerable measure of suspicion and, accordingly, comes in for a fair amount of (sometimes rather ill-natured) banter, he is quite confidently expected to work therapeutic miracles and in double quick time."

Then Strauss added: "Sometimes he does."

The urgency and poignancy of man's problems in a nuclear age—an age so rich in material abundance, at least in our culture, yet so remarkably barren of real security—are contriving to place psychiatry on an elevated plane to which it is not at all accustomed. It is disconcerting to find that we are expected to have at our fingertips all the answers for

"The onward stream of scientific thought, although unhalting, yet so twists and eddies that the direction of its general trend may not at a given moment be plain to read."¹

These, the words of Sherrington, are particularly pertinent to the topic which I am about to discuss. Trends in psychiatry are difficult to delineate at any particular moment in time because they issue so gradually from things which have gone before and because what seem to be important new developments are actually not new at all, or, if they are, they too often miss their mark and fall by the wayside. We can only say this with any surety: Psychiatry is interlaced, as it has always been, with the prevailing concepts of man—of man and his nature, of his place in the universe, of his purpose and his destiny, of the forces that impinge upon him.

The democratic concept and the new social consciousness at the end of the 18th century ushered in the great movement in the humane care of the mentally ill associated with the name of Pinel. Today that democratic concept lives ever more strongly in our midst, and social consciousness has expanded and grown until it envelops every aspect of our culture. Yet the great movement in hospital psychiatry instituted by Pinel has not kept pace. That is the inescapable fact of modern psychiatry, charged as it is with keeping to itself every patient whom society is unable to assimilate, yet in no position to undertake the treatment indicated in all cases. The inescapable fact is that the public has failed to identify itself with the goals of psychiatry and that the possibilities of psychiatry cannot be fully exploited. For, while it is also true that attitudes toward psychiatry have changed for the better, patients who are sick in our public mental hospitals continue to live *en marge* of the society of which they are a part.

It is certain that attitudes toward psychiatry have changed. The psychiatrist is accepted, if his patients

Delivered before the Philadelphia Psychiatric Society, October 12, 1956

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the foibles of human behavior when we have had, in fact, neither opportunity nor encouragement to find the answers to major problems of clinical practice.

The march of science and medicine has brought protection, or the possibility of protection, against many of man's ancient enemies, but the advance is fraught with hazards of a different kind; and little has been accomplished by any science, including psychiatry, actually to contain the enemy within, which keeps man in personal and collective danger. Here indeed, ". . . the loom of life never stops, and the pattern which was weaving when the sun went down is weaving when it comes up tomorrow." (Henry Ward Beecher.) Truly preventive psychiatry, which is expected of us already, lies, we fear, far in the future. Preliminary plans are on the drawing boards, but there they will languish as they await the specifications that can only come from the identification of causes. That these causes are multiple is only too clear. That they are complex is even clearer. That some of the answers will be found in areas as yet unexplored is clearer still.

INTEGRATION WITH MEDICINE

We can speak with more assurance, perhaps, of trends in the practice of psychiatry. One of these is of the greatest possible importance: the integration of psychiatry with the field of medicine. It is a trend linked with the changing practice of medicine: the decline of so many of the acute and infectious diseases of yester-year and the rise of chronic afflictions and particularly of illnesses associated with and based upon emotional disorder. Comprehensive medicine is on the march after long years of compartmentalization. Doctors of medicine, dazzled by the vast accomplishments of scientific method, forgot for a time that disease is something that occurs against the background of the environment, in and to an individual; that the individual puts something, often everything, into his illness; that illness and cure may be adventitious even as they are each, many times, fictitious. It is a far cry from the medical astrology of a few centuries ago to today's scientific medicine, but scientific medicine cannot be separated from the art of medicine and vital doctor-patient relationships.

The loss of the wisdom of our predecessors was the price we paid for a spectacular technology. With the growth of knowledge about what causes and constitutes disease, about its treatment and its prevention, medicine flowed freely into innumerable

separate channels. Specialization laid its mighty hand on clinical practice, with tremendous gains to most patients, but with serious loss to those whose disability, because it was overdetermined, may we say, continued long after presenting symptoms had departed and had changed perchance to other and more malignant conditions. That the compleat physician has been a rarity far too long has become as clear to the public as it has to the profession. Patients resent the apparent impersonal approach, the feeling that they are no one doctor's individual responsibility, the impression they sometimes have that the one hand knows not what the other is doing, and cares less. This gross defect of modern medicine is in the process of correction; medical thought is shifting toward a more unitary concept of health and disease, a more pointed attention to the person in the body, and a better integration of medicine in line with changing epidemiology. In the new comprehensive medicine of the future, psychiatry should occupy a position of prime importance and it may well be the mortar that holds together a truly functional edifice.

The integration of psychiatry with medicine is bringing the psychiatrist out of his mental hospital fortress into the community, and into cooperative relationship with community physicians who are, or should be, the first line of defense against mental ill health. The doctor in community practice is in a favorable position, if he will but use it, not only to spot incipient psychiatric disorders and to see that they are attacked at a time when they are most amenable to modern psychiatric treatment, but also to treat minor emotional illnesses in his patients. The family doctor has a preventive role of special distinction, for his patients fall into all age groups and all social classes. The future control of mental illness is largely in his hands.

Psychiatry, then, is intertwined with general medical developments and its influence is making itself felt in our public and community health services. The psychiatrist is taking on heavy consultant and educational duties in the community, as well as in the outpatient clinic and in the general hospital. This is as it should be. For psychiatry will receive from the community in accordance with its evident contribution; and psychiatry needs understanding and support on the broadest possible base. Unless the community identifies itself with the needs and goals of the mental hospital, just as it has identified itself with those of the general hospital, there

will be little animation in any of our mental health services and mighty slow progress in revitalizing our public psychiatric hospitals, however large and howevery sturdy they become.

Psychiatrists in private practice are doing much for the integration of psychiatry and medicine. Though their sphere of clinical operation may be limited, particularly if they are engaged in the practice of long-term psychotherapy, they are certainly changing the climate of opinion about the possibilities of modern psychiatry. One of the most pronounced trends of recent years is actually the exodus of newly trained psychiatrists from the mental hospital into community practice. Unquestionably private practice is economically and personally more rewarding to the young physician, and if he is equipped for comprehensive service, he can do heroic work in the community as therapist, diagnostician, educator, and consultant. He can undoubtedly keep many patients out of institutions and refer those he can not early enough for successful treatment. This exodus of psychiatrists into private practice has its serious drawbacks, however. It is not easing the staffing problems of mental hospitals, nor the work of hospital psychiatrists who find themselves, as of old, in the discouraging medical situation of being surrounded on all sides by apparent failures. The scarcity of hospital psychiatrists is an appalling spectacle even in our most modern and well supported state hospitals. Patients by the thousands continue to be deprived of the attention which is their due, and doctors are deprived of the right to practice their profession in line with their competence and in line with the medical tradition which holds that the doctor's job is to restore his patients to a normal life.

TRAINING, EDUCATION AND RESEARCH

Shortage of staff, researchers, nurses, personnel at every echelon—this is what we continue to see and sometimes it means a tragic and archaic caricature of psychiatry. Because it does mean this, efforts are in progress in every section of the country to change the situation. Efforts are being made to lay the groundwork, at least, for the conversion of mental hospitals into therapeutic communities and centers of education, training and research. At the national and state levels, more funds are being made available for these purposes. Training grants and scholarships are on the increase, together with grants for pilot projects in new ways of handling the men-

tally ill. The expansion of research is being granted high priority. Unfortunately, here again the human element—the research scientist—is not readily available. It is of utmost importance to cultivate the research spirit in young psychiatrists and to enlist the services of trained investigators from other related fields. The trend is certainly in this direction already; and the time may not be as far off as one fears when research will be an integral part of every mental hospital program and in reasonable coordination with clinical and teaching work, so that techniques and procedures essential to investigation may be most effectively communicated. Our research problems are many and complex. With funds available and interest high, it would be a grave disaster to be unable to find the people capable of undertaking the exploratory work so urgently needed. Research must proceed in many directions, and we must be sure that we are preparing young psychiatrists to chart these directions. Training must be broad enough to orient residents in the various areas in which research would be most rewarding. In his recent book, "Mental Health Planning for Social Action," Stevenson spoke eloquently of this problem:

"If the training of a profession consists of indoctrination by a certain 'school' while other approaches or 'schools' are neglected, there is little incentive to inquiry and experimentation. In order to stimulate research the training of a profession for practice should provide an understanding of all the pertinent facts, theories, hypotheses and techniques that bear upon the practice and an understanding of the scientific status of each. Thus the uncertainties and gaps of science are brought into clearer relief and inquisitiveness is fostered. The trainee is then ready to acquire research skills, for he has imagination and also the incentive to find answers to the wish: 'If we only knew more'."³

These considerations weigh very heavily, along with the stark current need in psychiatry for the broadly trained men who can deal with the rank and file of patients, in favor of equipping as many young psychiatrists as possible for comprehensive service.

TREATMENT IN PSYCHIATRY

Psychiatric therapy is advancing. We find ourselves today in a period in which somatic treatment of various types, with a strong turn to the biochemical, is opening up new possibilities for our patients, not

only because it is bringing under symptomatic control some of the most disturbing aspects of mental illness, but also because it is facilitating the psychotherapeutic contact essential for effective psychiatric treatment. There is a downsurge in the use of the so-called drastic therapies, particularly psychosurgery, though the occasional need for it is recognized. Even though it is justifiable and perhaps necessary in certain cases, it should be, as Strauss observes, relegated to the museum of grim, outmoded neurosurgical curiosities as soon as possible. The use of insulin therapy has declined, despite its apparent value in many cases of schizophrenia, and even electroshock is ceding in some quarters to the more facile new tranquillizers. It is unfortunate, of course, that the quest for a panacea continues to be so compelling that one is tempted to abandon older instrumentalities which have made such a difference in psychiatric practice. Some people speak eloquently of the unprecedented transformation of mental hospitals since the advent of the ataraxics; others call these drugs the psychic chemotherapy of the future. Indeed, they may well turn out to be psychiatry's most powerful allies. They certainly affect mood and influence behavior in many patients and, indirectly, they have a similar effect on the treating doctor. At the same time, until all facts are in, we must exercise caution and restraint, keeping, as Sargant recommends, an open mind about the value of all treatments, as we bend our efforts to differential search for improved methods and combinations of methods.⁴ Pharmacologic psychiatry will undoubtedly play a very great role in the way psychiatry develops in the next decade. If the promise of the new drugs is fulfilled, great changes will be forthcoming in psychotherapeutic technique. For, as Hoch reminds us, if it is possible to reduce an individual's anxiety or to increase his ego strength with drugs, the psychotherapeutic problem with such an individual will be different than it has been in the past.⁵

What we need, and need desperately, is a better scientific evaluation of all our treatment methods so that we may work with a confident sense of direction. Inadequate evaluation is especially obvious in psychotherapy. We have yet to establish what kind of patient can benefit from what kind of psychotherapy, short or prolonged, symptomatic or reconstructive, individual or group. Controlled designs and projects are not easy in psychotherapy because of the wide variations in individual patients

and therapists, the multifactorial nature of the therapeutic process and intangibles of many kinds. Yet they are of critical importance because every new finding only confirms the view that psychotherapy is the backbone of psychiatry. Attempts are being made to augment and improve follow-up studies of treated patients and to organize evaluation projects which will have predictive value for psychotherapy.

A major trend in psychotherapy is to apply the basic principles underlying intensive psychotherapy to all types of mental illness. Recent developments revolve around the mutual and collaborative contact between patient and physician, with special emphasis on modes of interaction and communication. They feature also the environmental influences to which the patient has been subjected, so that patients' relatives are figuring more prominently in treatment programs, either directly in patient-relative and, indeed, relative-relative group therapy, or in social work involving the reorientation of families to the patient. Moreover, the principles of psychiatry and psychotherapy are being studied in the framework of the social sciences, cultural anthropology and other behavioral sciences, and interdisciplinary research is placing helpful guide lines on the directions we are taking.

SOCIAL PSYCHIATRY

We are, in fact, in a really revolutionary period in which a new social psychiatry is being written. We are certain today that much of the problem of psychiatric disability is causally related to the social environment of the patient, as it is now and as it used to be. The important people—the significant adults, as Sullivan calls them—in the childhood of the individual do much to mould the destiny of that individual. Moreover, the social environment in general contains precipitants in profusion for mental ill health, and a wealth of perpetuating agents. The old psychiatrists, until they became preoccupied with the theme of constitutional degeneration, knew this to be so and acted upon it resourcefully in the treatment of patients. Esquirol remarked upon the great variation in psychic symptoms occurring under the impact of major social events, such as war and revolution. A century and a half later French psychiatrists were observing a similar phenomenon. Among other things they noted a decline in hospitalization rates for the functional psychoses in time of war, a decline they were unable to attribute

entirely to greater tolerance of the social environment, for patients whose psychoses arose on an organic basis were seen in their usual number. This observation was also made, you will recall, in World War II by the English psychiatrists. Their psychiatric clinics had far fewer patients than was ordinarily the case.

Further than this, there seem to be variations in the proportions of different psychoses and even in their symptoms among different ethnic groups; and as the Yale group has found, social mobility seems to be related to psychoneurosis and schizophrenia, both types of patients showing stronger upward mobility than the average population and also than their parents and siblings. Though this does not hold for all neurotic and all schizophrenic patients, the trend is sufficiently pronounced to belie the downward drift hypothesis of schizophrenia. It seems, as the Yale people say, that neurotics and schizophrenics, at least prior to the onset of illness, are achievers and possibly over-achievers. There is indeed a discrepancy between achieved and aspired mobility, one which furnishes an interesting quantitative index of the patients' lack of ego strength and their subsequent flights into phantasy.⁶

It is clear that research in social psychiatry should bring tangible rewards. For it illuminates the psychology of patients as members of social units and shows the importance of the social setting in which treatment takes place. Significant work has been done; more is in progress. The accumulation of data on the family and community constellations in which patients have lived and broken down has been examined for its psychotherapeutic implications, and to good effect. Its impact is already evident in group therapeutic procedures and in psychodrama, and we are revising our thinking about our responsibility after the patient returns to his community. It is not enough to speed him on his way. He may not make the grade without further help in the day or the night hospital set-up. He may need the services of the psychiatrist in private practice. He may need the assistance of the social worker. He may need a sheltered work situation. Linn tells us of the legendary patient who was told by her psychiatrist: "You are cured. Now go out and find your niche in life." Needless to say, says Linn, this patient quickly returned to the hospital because the only niche to which she was able to adapt was that which she had carved out for herself in the hospital, and because preparation for community living had

been omitted in the hospital's treatment program.⁷

Daumézon has vividly described the problem of hospital enrootment in connection with patients who, though clinically recovered, relapse or threaten to relapse at the prospect of ejection into the turbulent world outside. Dr. Strecker, Dr. Burgess Gordon and I noted this in a study of patients in a tuberculosis hospital over twenty years ago. Some patients who feared the pressures which life outside would require of them could always manage by well known methods to have a relapse at the time discharge was contemplated. These patients from mental hospitals have usually been in hospital for a considerable period of time. At the moment of remission, doctor and patient measure the real difficulties of social integration and tacitly agree to wait. But the patient quickly consolidates his position in the hospital. He looks about for tasks he can accomplish, gains the confidence of people, and gradually integrates himself in the life of the establishment. After a time he finds himself, in truth, a pillar of the institution. He has identified himself with it and is full of its history. His loyalty is exemplary. It is he who puts out unneeded lights, closes windows, and so on. He has made a regressive, though not too regressive, social adaptation—one not difficult to make by an individual whose previous financial, professional, familial and social situations have been precarious. But it is one facilitated above all else by the hospital climate in which group life serves, not as an instrument of socialization and orientation to normal society, but rather as a stimulus to the abrogation of responsibility. Enrootment of this sort, writes Daumézon lugubriously, can be overcome "only by furnishing the subject an equivalent integration in a milieu as close as possible to that which one wishes him to abandon."⁸

This is just another aspect of the social factor as a noxious agent. That psychiatric disorders of all kinds occur in batches within certain families is an observation of long standing. Well before the delineation of clinical entities this phenomenon was extensively studied, to end in the gloomy obsession with constitutional degeneration. The relative impotence of psychiatric treatment toward the end of the 19th century was a reflection of that obsession. Kraepelin labored under its yoke, though he finally emancipated himself to some degree. He came to believe, for example, that dementia praecox is an acquired disorder, with heredity a contributing factor, and Bleuler, in speaking of multiple schizo-

phrenias in a given family, asked in turn: Is this due to common heredity or to a common source of infection? He was speaking of a toxic factor, of course, and one of chronic nature; yet despite that emphasis he recognized psychological influences at work in the elaboration of secondary symptoms and did much to undermine the therapeutic nihilism that prevailed. Today we are asking, and to better effect from the preventive and therapeutic points of view, whether functional psychoses do not as a rule occur in persons nurtured in a particular family constellation and a highly specific socio-cultural environment. This is leading us to the study of total family dynamics and the general cultural milieu of our patients, as well as individual psychopathology and psychodynamics. We are striving for what Rennie called a "better awareness of the total family as a homeostasis, of how the illness of one member may upset the balance of the others, leading sometimes to a breakdown of their adaptation."⁹

Further knowledge of family and community dynamics will be of great directional value in preventive psychiatry, which is the area in which we are most derelict and most poorly prepared. We are being asked to say what goes into the making of a psychiatric disorder and what can be done to prevent it. Our answers are hardly satisfactory. The more we investigate, the more evidence we find that there is no one pathogenesis in psychiatric disorder, and that we are probably dealing with reaction types associated with a wide diversity of causal factors. Among these factors, those which tend to disturb the individual in his intra- and interpersonal adjustment figure largely.

MENTAL HOSPITALS

Certainly these factors are of great importance in the management of patients. Work now in progress in our mental hospitals demonstrates their importance persuasively. Stanton and Schwartz have collected material indicating from many different points of view that a mental hospital ward is an interacting system in which the type of activity engaged in by any one person depends to a high degree on the other people in the ward. By viewing mental illness as a type of participation in a social process, these authors have identified meaningful patterns in the occurrences in a mental hospital, and have illustrated the effect of such patterns on the progress or retrogression of patients.¹⁰

From custodial to therapeutic care in mental hospitals is a preferential theme in the psychiatric literature. The therapeutic community is what we all have in mind. One of the best exponents of this is Maxwell Jones, whose therapeutic community for a psychopathic population is patterned on the outside community. The results of the program he describes offer additional evidence for the importance of the therapeutic culture in any psychiatric hospital and for the large role that patients themselves may play in it.¹¹

Greenblatt and Linn have talked along the same lines. In his book on hospital psychiatry Linn writes as follows:

"In the therapeutic community the whole of the time which the patient spends in the hospital is thought of as treatment time and everything that happens to the patient is, or should be, so regarded. . . . Viewed thus, the appearance of grounds, the structure of the buildings, the arrangements of the wards, the decorations on the walls, the way the food is served, are all part of a program. All personnel from the guard at the outer gate to the medical administrator in the main office are part of the program. All activities, recreational and occupational, are organized with regard to maximal therapeutic effectiveness. The relationship between patients is part of the plan. The emotional problems which arise among personnel are important factors in the therapeutic community. . . ."

It is of interest that most of these emphases were also made in the era of moral treatment.

The interpersonal, social and cultural orientation, which had fallen into disrepute, or at least into neglect, since the days of "moral" treatment, is again illuminating the clinical practice of psychiatry. In its new format it can do much to aid and abet us in the work we are doing with other therapeutic methods, general and specific. The old lock and key institution is under attack, and for good reason. For closed doors have not only imprisoned and hastened the deterioration of patients; they have also excluded the community. Now, in many quarters, this seclusion and exclusion is erasing itself. The atavistic demon fence, as Dr. Paul Haun calls it, is disappearing; the community is beginning to come in and help; patients are being brought into cooperative efforts; the influence of the group is being used in a social setting to help the individual. It is interesting to note how we rediscover things

in the practice of medicine. Now our emphasis is upon social setting, community actions, group living and permissiveness, rather than authoritarianism. Listen to Eli Todd, the first director of the Hartford Retreat, in a document from the year 1826:

"Insanity in most cases is a disease in which the moral and intellectual faculties are not destroyed, but some one or more of them are in a morbid condition; perhaps in a state of unequal excitation, some acting with too much, others with too little energy, and by this inequality disturbing and breaking up the order, series and just proportion of relations which previously existed in the mind between its own ideas and external things. The great design of moral management is to bring those faculties which yet remain sound to bear upon those which are diseased, and by their operation to modify, to counteract, or to suspend their morbid actions. This constitutes the process of self control, the groundwork of cure, the grand tactical principle which is to decide the issue of the contest between reason and insanity. To effect all this successfully requires an art too refined and too difficult to be exercised in perfection. . . .

"Fortunately there are certain plain and simple maxims in the moral treatment of insane persons which are easily understood and of universal application. These are to treat them, in all cases, as far as possible, as rational beings. To allow them all the liberty and indulgence compatible with their own safety and that of others. To cherish in them the sentiments of self respect. To excite an ambition for the good will and esteem of others. To draw out the latent sparks of natural and social affection. To occupy their attention, exercise their judgment and ingenuity, and to administer to their self complacency by engaging them in useful employment, alternated with amusements. To withdraw, in most instances, their minds as much as possible from every former scene and every former companion, setting before them a new world and giving an entire change to the current of their recollections and ideas. . . . It is by no means intended to exclude the aid of medicine. For, as before observed, the mind and body are so connected that there can scarcely be a disease of either in which the other is not involved, and in which medicine and moral treatment may not be advantageously combined."

The acceptance of group dynamics among psychiatrists of all persuasions has been responsible for the decline of scholastic bias throughout the

specialty and has also helped in breaking down the barriers between psychiatrists and workers in other disciplines concerned with the behavior of man. It has been said that the group method provides a proving ground for the various therapies, and provides one of the best opportunities for training. With this we can, I think, all agree. We can also agree that group therapy and social psychiatry are producing exceptionally good results in the treatment of milder cases of psychiatric disorder.

The most urgent task we have continues to be the care and treatment of patients in our mental hospitals. But we are thinking, as we must, of our responsibility for making the mental hospital an integral part of the community it serves. Most existing institutions are obsolete. Many of them were built at a time when psychiatry was in its infancy, groping for clues to the understanding of mental illness and its treatment. They were built to get the mentally ill out of prisons and poorhouses, garrets and cellars, and into places in which there would be some semblance of humane consideration and in which patients would be kept isolated from society. They were built big, solidly, and for good, because it was assumed to be cheaper and more efficient that way. The architectural design became frozen and set and was imitated with few variations through succeeding generations. Today we are handicapped immeasurably by those bleak, forbidding, dysfunctional structures that served well enough for incarceration purposes but lend themselves poorly to modern therapeutic work. Under the best of circumstances it is difficult to make them into therapeutic communities in which the march of patients toward regression can be arrested or reversed. Doctors know how they feel about these institutions and by now there are numerous poignant stories about how the patient feels about them.

A sharp break with tradition is in order. There must be a change in the external configurations and internal atmosphere of mental hospitals. Concomitant with it, there must be a change of orientation in the community and particularly of the doctors in community practice. Necessarily psychiatric knowledge will have to be applied on a much wider basis than is presently the case. Only through the interest and cooperation of the family physicians, however, can real progress be made in diagnosis and treatment of psychiatric disorders at an early stage of their development. Only by integrating psychiatry closely with education and social sciences can

real headway be made in preventing the conditions upon which psychiatric disorders grow and flourish.

It is the thesis of modern psychiatry that the study and treatment of mental illness must include the whole situation of the patient—his total personality, his biography, his environment, his relationships. The mental hospital of the future will be a therapeutic community, patterned as much as possible on everyday life. It will be an integral part of the community which it serves. To its historic functions of essential custodial care and treatment will be added educational activities, not only in the training of many more psychiatrists, psychiatric nurses and auxiliary personnel, but also in the education of physicians outside the specialty, and indeed of the laity as well.

Day hospitals are on the increase, and they represent one of the most heartening developments of the last decade. The day hospital should be equipped to handle all classes of psychiatric problems, including those prevalent in older age groups. In it may lie some hope for lightening the geriatric burden, relieving stress in the individual and the family, and improving the climate of the community itself.

CONCLUSIONS

I have spoken of the compartmentalization of medicine and the new integration movement with which we are so greatly concerned. The same trend is evident in psychiatry. Psychiatry from its beginnings moved in great avenues and small bypaths. Its thinking ranged from the most purely philosophical to the most naturalistic concepts. Schools rose and fell in the wake of new speculations. They were ever remote from each other and wary of rapprochement. But today we are entering the determination on cooperative ventures in which the substance of each school and each era of experience is being distilled for the benefit of the mentally ill, and we are finding that the evidence laboriously compiled through many decades and from many points of view is converging in a very remarkable way. The insights dating back to the dawn of enlightened hospital psychiatry are finding confirmation and a new meaning in social and interpersonal psychiatry, which in turn is fortifying and enriching the brilliant psychological and medical discoveries of the 20th century. Though we are in a period of change and innovation, we are mindful of the old wisdom laboriously inscribed for us by succeeding generations of thoughtful students of the mind.

And we are mindful of our unity with each other. For we have, not only "because human," as Sherrington wrote, but also as physicians, and especially as psychiatrists

" . . . an inalienable prerogative of responsibility which we cannot devolve, no, not as once was thought, even upon the stars. We can share it only with each other." (Sherrington—*Man on His Nature*.)

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Diabetic Film Available

The film "Urine Sugar Analysis for Diabetics," developed in cooperation with the medical profession, is available at no charge to the Medical and Allied Professions through Ames Company, Inc.

The film was made as a visual aid to be used in the education of diabetic patients and shows the relationship between carbohydrates and insulin. It also explains in lay language the meaning of various diabetic conditions. It has been produced on 16 mm. film in color and sound track with a running time of approximately 10 minutes. Appropriate "hand-out" literature accompanies the film.

Showings at Diabetic Clinics, Diabetic Lay Societies and other diabetic groups must be requested by the Medical or Allied Professions to Ames Company, Inc., Elkhart, Indiana or an Ames representative.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

Telephones: UN 5-0587, LO 2-0836

COUNCIL MEETING

The monthly meeting of the Council was held at the offices of the Society on March 27, 1957 and was called to order by the Chairman at 4:30 P. M. There were present in addition to the Chairman, Dr. Fincke, Drs. Ogden, Walker, Couch, Barker, Feeney, Stringfield, Gallivan, Tracy, Otis, Kristan, Meyers, Buckley, Dwyer, Starr. Absent were Drs. Weld, Danaher, Murdock, Gibson, Ursone, Archambault, Ottenheimer, Clarke, Gens, Gilman.

An informal statement of the Society's financial operations was presented to the Council and discussed briefly. A copy is attached to these minutes.

SB258 which would redefine chiropractic and is now pending before the Connecticut General Assembly was discussed at length. Dr. Alfred L. Burgdorf, chairman of the Society's Committee on State Legislation and Dr. Louis P. Hastings of the Connecticut Medical Examining Board had been invited to be present to participate in this discussion because both of them had served, with the executive secretary, on the Conference Committee with representatives of the Connecticut Chiropractic Association that had drafted the definition of chiropractic which is now the basis of SB258. It was pointed out that this Conference Committee had not committed the Society to sponsorship of this legislation and after discussion lasting more than an hour it was agreed that the chairman of the Legislative Committee, Dr. Hastings and Dr. Barker attend the legislative hearing on this bill which is scheduled to be held on the afternoon of March 28 to make it clear to the Committee that with certain changes relating to the practice of physical therapy, the bill as presently drawn is approved by the Council.

It was noted that Egbert M. Andrews, Hartford does not wish to be renominated as a member of the Committee on Medical Care of Veterans and his name was withdrawn from nominations to the Committee for the year 1957-1958. No nomination as a replacement to Dr. Andrews was made.

Voted to table a request from the Committee on

the State Blood Bank for an appropriation of \$500 "to cover the cost of mailing two news letters to members of the State Society on specific subjects of special interest to the physicians of this State" until the Committee had provided the Council with a detailed statement of the necessity and purpose for such news letters.

A number of items concerning the medical phases of civil defense were grouped and discussed. Particular emphasis was given to the Annual Report of the Society's Committee on Emergency Medical Service which had recently been submitted by the chairman of the Committee, Benjamin Whitcomb. In that report it was recommended that the Committee on Emergency Medical Service be discharged and discontinued and that a new Committee on Casualty Planning to serve as an Advisory Committee to the State Office of Civil Defense be established. It was voted that the Committee on Emergency Medical Service be discontinued and that a Medical Advisory Committee to the Office of Civil Defense be created at a later date when its purposes and functions were better understood.

A communication from Dr. Eugene F. Kalamán, Bridgeport, was presented concerning the "indignity" of the 25¢ filing fee for filing of death certificates. It was pointed out that this fee is established by law in Section 1981d of the General Statutes. The matter was discussed briefly and the secretary asked to determine when the payment of this fee was first put into the statutes.

Three requests from the chairman of the Sub-Committee on School Health were presented:

1. That the Society invite the Connecticut Association of Public School Superintendents to be a co-sponsor of the Second Connecticut Conference on Physicians and Schools. It was voted to approve this proposal.

2. That the Council authorize the Sub-Committee on Schools to employ Manpower, Inc., Waterbury, to handle the correspondence and secretarial work for the Second Conference on Physicians and Schools which is proposed to be held on November 7, 1957 in the auditorium and other facilities in the Connecticut Light & Power Co. building, Berlin. It was voted to not approve this proposal and to inform the chairman of the Sub-Committee on School Health that secretarial assistance relating to the Conference on Physicians and Schools would be provided by the office of the executive secretary of the Society.

3. That the Society appoint a Committee on Nutrition. Voted to ask the Committee on Public Health for an opinion concerning the desirability and purposes of a Committee on Nutrition.

It was voted that the Society would contribute \$50 to help to meet the expenses of a two day conference on "Moving Ahead with Nutrition Education" to be held at the Hotel Bond, Hartford, May 20 and 21, in celebration of the 10th anniversary of the Connecticut Nutrition Council.

It was voted that the Society not serve as a sponsor of the essay contest of the Association of American Physicians and Surgeons.

Authorization was voted for the payment of \$75 for annual dues for 1957 to the Conference of Presidents and other officers of State Medical Associations.

It was voted to approve the recommendations of the Committee on Industrial Health to oppose SB242, SB750, SB754, HB328, and HB349.

HB2165 now pending before the General Assembly would consolidate the functions and purposes of the State Commission on the Care of the Chronically Ill, Aged and Infirm with the Tuberculosis Commission and transfer the Woodruff Rehabilitation Hospital, New Haven, to an agency for the care of mentally deficient. This is a Committee Bill which has only recently been introduced and copies available the day before this meeting. There has been little chance to study the bill and its far-

reaching implications. It was not discussed at this time but was referred to the Chairman of the Committee on State Legislation for appropriate study and action.

A guide to the Standards and Recommendations for Hospital Care of Maternity Patients which had been prepared by a Sub-Committee of the Society's Committee to Study Maternal Mortality and Morbidity was distributed to members of the Council as a matter of information and possible later discussion. The proposals made in the guide have already been approved by the Public Health Council of the State of Connecticut and are now under consideration of a Sub-Committee of the Society's Committee on Hospitals.

It was voted that the date for the Annual Meeting of the Council be set tentatively for May 9.

The meeting adjourned at 6:30 P. M.

Meetings Held in April

- April 1—Woman's Auxiliary Board
- April 2—Connecticut Medical Examining Board
Hartford County Medical Association
- April 3—Liaison Committee, State Blood Bank
Indoctrination Meeting, Fairfield County
Medical Association
- April 4—New London County Medical Association
- April 8—Medicare Committee
Committee on Eye Care
- April 9—Fairfield County Medical Association
- April 10—Sub-Committee of Council on Hospital-
Physician Relationships
- April 11—Middlesex County Medical Association
- April 16—Tolland County Medical Association
- April 17—Committee on School Health
- April 18—Windham County Medical Association
Litchfield County Medical Association
- April 24—Committee on Perinatal Morbidity and
Mortality
Sub-Committee on Toxemia
Committee on Accident Prevention
- April 30—Annual Meeting, House of Delegates

RESULTS OF MEMBERSHIP REFERENDUM ON
COMPULSORY SOCIAL SECURITY FOR PHYSICIANS
MARCH - APRIL 1957

COUNTY	NUMBER MAILED	NUMBER RETURNED	PER CENT RETURNED	YES	YES PER CENT TOTAL	YES PER CENT RETURNED	NO	NO PER CENT TOTAL	NO PER CENT RETURNED
Fairfield	778	469	60	332	42	70	137	17	29
Hartford	911	613	67	512	56	83	101	11	16
Litchfield	131	80	61	44	33	55	36	27	45
Middlesex	106	68	64	33	31	48	35	33	51
New Haven	898	512	57	368	40	71	144	16	28
New London	173	101	58	62	35	61	39	22	38
Tolland	20	10	50	10	50	100	0	0	0
Windham	60	42	70	30	50	71	12	20	28
Total	3,077	1,895	61	1,391	45	73	504	16	26

Seventeen incomplete cards were received and are not included in tabulation.

344 physicians who replied stated they were now covered by Social Security. Some of them answered the yes-no question and they are included in figures above. If they did not answer yes-no question they are not included above but are included in the 344 figure in this note.

Analysis of replies by age groups produced no significant information.

INSURANCE AND THE PHYSICIAN

BASIC QUESTIONS ON HEALTH INSURANCE AND WELFARE PLANS

JOHN G. MORRISON, M.D., *Oakland, California*

1. Which type of plan offers employees the most medical care per dollar spent—insured plans, closed-panel plans, hospital service plans such as Blue Cross, or medical service plans such as Connecticut Medical Service?

We of the medical profession are concerned with the attitude this question displays: namely, that there must be some way of reducing the cost of good medical care if only we find the right elaborate system. Good medicine is expensive and it is going to become more so if medicine continues to progress and to require the services of highly trained doctors, nurses and technicians. I think we are going to have to get over the idea that the economic consequences of illness can somehow be escaped, if we just can find some magical way of paying for them. You can buy anything you want to pay for from any one of the four plans you mention. The question of which offers the most medical care per dollar spent, I feel, depends on a number of things. It will depend on the kind of group that is insured; the efficiency of the company and its claims handling; and the willingness of the company to experiment and pioneer in filling the legitimate needs of people. If you are a member of any insured group, you or your committee should get from the insurance company as much information as possible as to total premiums paid in and total amount of money paid out in actual medical benefits. You may be sure that when the second exceeds the first, the insurance company will quickly let you know. I think that you, as a member of an insured group, or your committee should see to it that a legitimate portion of the premium paid in actually redounds to the membership in the form of medical care. I would give, therefore, the following general answer to the first question: The plan which delivers the best and most satisfactory medical care will be as simple as possible. It will interfere as little as possible with the

The Author. *Secretary-Treasurer, Alameda-Contra Costa County Medical Association*

SUMMARY

Nine questions on health insurance and welfare plans considered basic are propounded. Each is answered succinctly and briefly. Medical economic problems do not permit emotional discussions. Insurance companies provide cash returns based on income received. The private practice of medicine continues to be the best system of medical care.

therapeutic personal relationship between doctor and patient. It will permit the patient to retain his ultimate responsibility for his own medical care. It will allow him to "fire" one doctor and "hire" another without economic sanction.

2a. Should it include surgical benefits? If so, on what schedule?

I think we must all agree that any good health insurance plan will include surgical payments. Surgery is, of course, an expensive and unpleasant physical and economic emergency. It is usually unpredictable. Therefore, this is a need which can truly be filled by insurance.

2b. On what schedule should surgical benefits be included?

Any good insurance man will tell you that a person who suffers a loss should not, through his insurance coverage, be made better off than before he suffered the loss. This is an axiom of insurance. I think that it must be applied to health coverage this way: Wherever possible one should determine what the costs of surgical care in an area actually are—and then establish a surgical schedule which approximates those costs.

Reprinted from an address given before the Commonwealth Club of San Francisco in December, 1956 and published in the Alameda-Contra Costa County Bulletin by permission of author and editor.

3. Should negotiated health plans include home and office doctor visits?

In my opinion, no, it is not economic unless controlled coinsurance principles are followed. Home and office calls pose the economic problem of an effective control of over-use and unnecessary service. I feel that coverage for these items can only be effective by the application of coinsurance, which means the patient pays directly a part of the expense, in addition to that portion paid by his insurance. It is important, however, that each group determine the amount of this coinsurance in advance, so that it would not constitute a severe financial hardship on the user and, therefore, defeat a major objective of health insurance. In the course of our discussions in the Medical Association we were at one time presented by an insurance company with some statistics to the effect that the size of their average claim on a certain insurance group was something like \$18.75. They also told us that the cost of administering those claims—the total cost of receiving the claim, checking the form, engaging in the necessary correspondence, writing the check, and doing the bookkeeping and accounting—amounted to something like \$8 per claim. The point I am making is readily visible. The terms of this health insurance policy were such that 25 per cent of the patient's money was not going to pay for medical care at all. What that insurance plan was trying to do was to pay for everything for everybody every time they got sick. Any time Johnny or mamma experienced a \$4 office visit for little Johnny's sniffles or mamma's headache, they sent the bill to the insurance company which in turn, paid for perhaps \$4 worth of medical care by adding to it the cost of \$8 worth of paper work for a total bill of \$12. This is not necessary. It is obvious there are very few families who cannot afford an occasional visit to the doctor's office. The incurring of a three, ten or even a twenty dollar debt will not prevent them from calling the doctor when they really need him. If, on the other hand, the insured family has the attitude that somehow they don't pay, but the insurance company does, the doctor may be called unnecessarily, and money is spent unnecessarily which could be better used to pay for the real economic difficulties real illness causes. In addition, the patient becomes unreasonably demanding and the doctor may find himself making house calls for hangovers. I have never heard of anyone suffering or dying because his

insurance policy did not provide for a \$5 office visit, and I don't think anyone in this audience has either.

4. Should negotiated health plans include major medical coverage?

Yes, I think they should. We doctors view with pleasure the advent and increase of so-called catastrophic or major medical coverage. We think that this is truly the necessary health insurance of the future and that it will bring about a more economic delivery of needed medical care to insured people. My answer to that is, yes, they should.

5. Should negotiated health plans include coverage for tuberculosis, for mental illness, for dental care, for optical examinations and glasses, and maternity benefits?

They should cover tuberculosis. Any large, costly disease, which is unpredictable and fairly infrequent, is amenable to the insurance principle. Tuberculosis appears now to fit in this category. But the character of tuberculosis as a medical and hospital problem has changed so radically in the past five or ten years that it is difficult to make any generalization about what kind of problem it will present in the future. Health insurance programs certainly should make some provision for the initial cost of hospitalization for acute mental illness. Much more could be done in the insurance of mental problems than is being done—once doctors, hospitals and insurance companies are free from the many prejudices that surround mental illness. I do not think that it is possible to insure all dental care, including the routine cleaning of teeth and filling of cavities, because these are rather routine expenditures. They happen to almost everyone and are to be expected in the normal course of things. On the other hand, I do consider that the cost of rebuilding an accident victim's jaw or mouth must legitimately be considered to be an insurable risk.

Optometric examinations measure your vision to determine the kind of glasses you should wear. I don't think it is sensible to insure this service. It is not really a loss, but merely a budgetary problem, since the need for glasses occurs to so many people and since the cost for providing them is seldom beyond the ability of most people to pay.

In the case of maternity benefits you have a situation in which insurance is being asked to act as a way of budgeting. Let us suppose that it costs \$300 or \$400 to have a baby—hospital and doctor bill. Most of us have at least seven or eight months'

warning, and we know that at the end of that time we are going to have this expenditure of approximately \$300. Now—which is the better way to save the \$300? By putting in the bank some \$40 a month for seven or eight months—or by paying fifty cents or a dollar a month in premium to a health insurance company for forty or fifty years so that each time any member of your group has a baby the insurance company will contribute some \$50 or \$75 to the cost of that child, and make a profit, pay administrative and bookkeeping expenses, and all the rest of it? I think that you should ask your insurance company to provide as nearly as possible for the serious accidents of pregnancy and for the expensive care that is necessary for premature babies. Accidents and prematures are expensive, they rarely happen, and they are unpredictable or nearly so, and are ideal subjects for the proper application of insurance.

6. Should county medical societies establish fee schedules for doctor visits, treatments and operations, and agree that they will not make charges in excess of the schedule for services rendered employees and dependents covered by negotiated health plans? I think they should make fee schedules with the intent to indicate the general level of medical costs for various medical and surgical procedures in their area. I do not think that medical societies either can, or should, agree that no medical doctor will make charges in excess of the schedule. My feeling about this does not come from a desire to enrich doctors. My feeling is dictated by several facts: Number one—a rigid fee schedule makes no allowance for experience, training, and skill. The recent graduate receives the same as the full professor. Number two—it makes no allowance for area differences; that is, the doctor in the downtown urban area is limited to the same fee as his confrere in the mountains with an office in his home. Number three—it makes no allowance for the demanding patient that we contend with frequently. Doctors sometimes for instance have to give tremendous amounts of care in an appendectomy and it is not equitable to ask him to do \$500 worth of work for the \$250 that a particular fee schedule may allow. It may be absolutely necessary that he do \$500 worth of work. If you are going to bind him to a rigid fee schedule, you then ask him, at a certain point, to give you charity—\$250 worth. This is not healthy and those rigid fee schedules which are in existence have often demonstrated that this is much

more than a theoretical danger. There is nothing to prevent an individual doctor from making such rigid fee schedule agreements with insured groups on his own, and many have done so at the behest for instance of various union officials. We feel this is a mistake, not so much from a doctor's standpoint, but from the standpoint of such an official who may soon find himself in the position of administering a poor quality of medical care to his own subscribers.

7. Should a plan's benefits be designed to pay the total cost of an illness, injury or operation? If not, what per cent?

We dealt with this a little earlier when I said it is an old insurance principle that when an insured suffers a loss he should not be better off than he was before the loss occurred, just because he happened to have insurance. I think this principle is perfectly applicable to health insurance. I think that a way must be found to make health insurance take over the largest portion of expense when the expense is highest, and to pay little or nothing when the expense is low. I think this is both good economics and good medicine. Nothing is more tragic or frustrating to a doctor, not to mention the patient, than to treat a long and difficult and time-consuming illness, and watch the day rapidly approaching when the patient must be transferred to a county or veterans' hospital because his health insurance has run out long before his need for it has ended. Yet it happens every day, in all plans—insurance, closed-panel, hospital and service—for there is no such thing as complete coverage. What is the "total cost of illness, injury or operation with every kind of injury, with cost is likely to be different with every kind of illness, with every kind of injury, with every kind of operation, and even more important, with every kind of patient who suffers each of these three events. Once again, the best arrangement is to give the doctor the maximum freedom to provide the very best medical care he knows how to provide. Let him charge fees in accordance with what are considered fair values for his services in his community, and, in the rare instance where abuse is discovered, confront him with your protest. If you are not satisfied, confront his professional organization.

8. Is malingering a serious problem, and if so, what can be done to discourage it?

Malingering I have always considered to be a

The second idea, which I think many of us must overcome, is the strange notion that the insurance company produces something—that somehow or

The third idea which I think we must get rid of, is that there is some special system which solves all of these problems, and that the doctors and their medical societies are simply too reactionary or too stubborn to see it, and are therefore responsible for all our medical economic troubles. This is, of course, too easy and too simple. There have been lots of ways of providing medical care. One way in the United States which still seems to please most doctors and most patients is the private practice of medicine as doctors know it. This system provides the greatest freedom in the practice of medicine and has produced the most progressive and finest quality of medical care ever known in the world. We think that this kind of medicine is still the medicine of the future.

This is similar to the proposed poison-control information center advocated in Connecticut for location in the Hartford Hospital and to the center already established in Stamford.

Special Article

THE CHILD GUIDANCE CLINIC OF WATERBURY, PAST, PRESENT AND FUTURE

KATHARINE HAWLEY MARTIN, M.D., *Watertown*

HISTORICAL BACKGROUND

The history of the Child Guidance Clinic is as old as the Mental Hygiene movement in this country. By definition, the clinic is a community-sponsored, voluntary health agency established for the purpose of providing service to the people of the community as a nonprofit, deficit-financed organization. Formally incorporated as the Child Guidance Clinic of Waterbury in December, 1951, the development of the Clinic can be traced back to 1918. At this time a Mental Hygiene Outpatient Clinic was organized, financed and conducted in Waterbury by the Connecticut Society for Mental Hygiene and this clinic operated one day a month for seven years. In 1925 the Waterbury Society for Mental Hygiene was founded as an organized branch of the Connecticut Society. The years from 1925 to 1931 reflected steady growth in clinical services as well as some educational work. The Clinic staff consisted of one or two psychiatric social workers and a part-time psychologist and psychiatrist. Financial support of the Clinic in this phase came from a few individual contributors and the Junior League. In the depression years the Clinic was aided primarily by the Second Congregational Church and was called the Life Adjustment Center and operated in the Parish House of that church. In 1935, however, this particular phase came to an end and the Society for Mental Hygiene was given one office in Lincoln House which is now known as the Family Service Association. The problem of financing professional services became more and more acute and it was not until 1942 when the Waterbury Community Chest was established that some assurance of relatively stable financing from year to year became possible. In 1948 the budget had reached the point where a full-time psychiatrist could be employed. Dr. Sayers, Dr. Arthur Jackson, Dr. Staneslow and Dr. Harty are familiar with many of the difficulties as well as many of the achievements of the Clinic up to this point. Quite a number of other physicians in Water-

The Author, *Psychiatrist-Director, Child Guidance Clinic of Waterbury, Inc.*

SUMMARY

Problems involved in establishing, maintaining and expanding a community child guidance clinic are discussed. Reference is made to financing, sponsorship, personnel requirements, professional team approach to the diagnosis and treatment of emotional disorders of children, referral, consultation, and educational services. There is immediate need for extending this type of professional service to all Connecticut children and providing opportunities for development of professional training programs. The importance of recent legislative action on a State level is noted.

bury participated in the work of the Clinic through activity on the Board of Directors.

There was never any question in the minds of the directors of the Clinic about the need for such a service in Waterbury. Through the rapidly enlarging Mental Hygiene movement throughout the country, which began in the early 1920's, the general public as well as certain professional groups had been learning about the important aspects of psychological factors in relation to physical illnesses and general well-being. Certainly the second World War opened the eyes of physicians to the broad extent of the neuropsychiatric problems. The discoveries of Sigmund Freud, Alfred Adler, Otto Rank, and C. G. Jung, followed by other psychoanalysts too numerous to mention, contributed greatly to the understanding of mental illness and to the concept of personality development. Unfortunately the wrong kind of attention and too much of it has at times been paid to provocative and unconforming ideas expressed by Freud and his colleagues, to the neglect of their constructive discoveries.

Presented before the Waterbury Medical Society, Waterbury, Connecticut, September 13, 1956

One of the most important factors in the development of personality about which we have learned in the last twenty years is the maternal-infant relationship. We have learned that a sense of trust in the mother begins to develop in the child from the time of birth on and that this sense of trust is essential to later development of healthy interpersonal relationships. Therefore, the most important outgrowth of a healthy maternal-infant relationship in the first weeks of life is the infant's trust in the parent which is then transferable to other people with whom he comes in contact in later years. Following this beginning sense of trust there comes a realization on the part of the child of his separateness from his mother. This occurs in the second and third years and is an extremely important phase of personality development. This is the time when the child discovers that he really is separate from his mother and separate from his father and that he has certain powers of his own. If all goes well and the parent allows him to experience this separateness in its fullest expression, the child can move on to the next stage where he develops further confidence in his abilities as an individual in his own right. He can accomplish things, he can do things with his peers and his siblings. This is an exciting stage of motor as well as social development. Despite certain differences in schools of psychoanalytic thought, there has been agreement on the basic concept that a child's personality development is intimately connected with parental attitudes and feelings.

In this historical picture of the development of the Child Guidance Clinic of Waterbury, between the years 1918 and 1948, the type of service reflected the changing concepts in the field of mental health. Increasing interest and attention was being paid to preventive aspects of work with children and parents as a way of preventing serious disorders in adult life. Interest deepened in the possibilities of dynamic psychotherapy with children and parents when the problems were discovered early and treatment began to replace or be added to the diagnostic services already provided. During this 30 year period between 1918 and 1948, the professional services of the Child Guidance Clinic had been on a part-time basis and of a generalized nature, that is, given to adults as well as children and a mixture of diagnostic, consultative and educational work. The important thing to remember, however, is that most of this was done by a part-time staff. One astonishing fact is that there were 16 different part-time psychiatrists during a

period of twenty five years. It can readily be seen by these statements that the problems involved in staffing the Clinic were many and that, as a result of frequent turnover of leadership from psychiatrists, there was inevitably confusion and lack of continuity in general policies. This was no different from the situation in many other communities. As a matter of fact, it was quite remarkable that Waterbury would have any kind of continued service for such a long period. Therefore, all this background experience served a good purpose, to the Board of Directors at least, who were clear in their general goals regarding the establishment of some kind of full-time, treatment-oriented, child psychiatric service when they could afford to do so.

PRESENT 1949-1956

The present developments in the Child Guidance Clinic of Waterbury may be considered as extending over the years 1949 to 1956. In the first three of these seven years the Clinic was continued as a service operated by the Mental Hygiene Society of Waterbury but in December, 1951 the Child Guidance Clinic was incorporated as a separate agency which had as its purpose a professional service. Also a separate agency was established under the name of Mental Health Association of Waterbury to provide educational services. There were two reasons for this separation of the clinic service from the educational type of organization. In the first place, the operation of a Child Guidance Clinic on a full-time basis was a full-time job for the Board of Directors. In the second place, there are distinct differences between a community organization established for professional services and a community organization set up to do general education and promotional work.

In 1949 the Clinic qualified as a member of the American Association of Psychiatric Clinics for Children. It is important to make note here of the nature of the Association just referred to. The American Association of Psychiatric Clinics for Children is a national organization which now includes about 110 clinics in this country and in Canada. The purpose of the Association is to establish and improve standards of practice in Child Guidance Clinics and it is an organization of clinics rather than individual memberships. Membership requirements include sound standards of personnel practices and certain specific requirements for the top three professional persons in the fields of child

psychiatry, clinical psychology, and psychiatric social work. Furthermore, one of the requirements of membership is that there be evidence of sound administrative organization and financial support, adequate office space for confidential interviewing and record keeping, and evidence of collaborative teamwork approach to diagnosis and treatment of problems of children and parents. This national organization of AAPCC was originated in the year 1946 and the organization, as a whole, has developed rapidly since that time. It so happens that the speaker has been a member of the Executive Council of the AAPCC and has considerable familiarity with the purposes, development and present trends in the organization.

Although the Child Guidance Clinic of Waterbury became a member of the AAPCC in 1949, the Board of Directors was confronted with problems of finance. Shortage of personnel in the professions of psychology, psychiatric social work and psychiatry was becoming so acute during these years that every community was faced with the same problem of financing the clinic and competing with other clinics for personnel. This was the first problem that confronted the newly incorporated Board of Directors of the Child Guidance Clinic in 1952. Fortunately a way was found to underwrite the operation of the Clinic for a three year period by a special grant of funds allowed by the Waterbury Foundation. This was in addition to the generous support provided by Federated Funds which is now the United Community Fund of Waterbury. Within this three year period every effort was made on the part of the Board of Directors and staff to explore ways and means of establishing sound financial support for a full-time psychiatric clinic which would mean a full-time psychiatrist-director, a full-time psychologist and at least two, perhaps three, full-time psychiatric social workers with necessary clerical staff.

It might be mentioned at this time that there were fees for service based on the cost of service and the individual family's ability to pay for such. This fee policy was organized in 1949 and the service was considered available to anyone and everyone in the Waterbury area. Some of the reasons for making this generally available included the fact that the service itself was unique and not duplicated by any private physician, or if duplicated somewhere in the State by private psychiatrists the cost was prohibitive as far as the average citizen was concerned.

In this respect, therefore, the Clinic was not a "free" clinic but a "fee" clinic. Nevertheless, there was no possibility of the Clinic supporting itself on the income from fees. This type of service has always been expensive and will always be, owing to the nature of training required for all of the professional disciplines involved in giving the service.

In 1953 a plan was conceived by the Board of Directors and the staff for a Regional Clinic which might draw for its financial support on a number of small communities in addition to the Waterbury municipal community. This plan was presented to the State Department of Health and was received with interest and support, in principle, but no funds were made available at that time. Only in the last year has the State legislature seen fit to establish a special act of legislation and provide money for State assistance to local community Child Guidance Clinics. The Waterbury Child Guidance Clinic is fortunate in being the recipient of \$20,000 for the next fiscal year in order to expand its services to areas outside of the Waterbury United Community Fund region. The staff now available for service includes a part-time psychiatrist-director, although a position is open for an associate psychiatrist-director; a chief psychiatric social worker and two other psychiatric social workers; a full-time clinical psychologist; two full-time secretaries. As a result of State assistance in the last few months, it is conceivable that the actual direct treatment service for children may be tripled and the treatment service for parents may be doubled. The area to be served is enlarged because, by law, any clinic that is receiving State funds for assistance will not be allowed to restrict eligibility to any specific community. In other words, the Child Guidance Clinic of Waterbury is available to anyone within the State.

Rapid developments have taken place in the field of child psychiatry, particularly in the period since 1946 when the AAPCC was organized. Psychiatric services for children differ in many respects from adult psychiatric services. The frame of reference is the family unit and one deals with problems of a child in relation to his siblings and his parents. Special training is required of the psychiatrist as well as the psychologist and psychiatric social worker. When one is dealing with a single adult individual who wants help for himself with his emotional problems, one trained person can help him. When a child needs help, he is a minor and his parents or parent substitutes must carry legal re-

sponsibility for any treatment plan and must themselves become involved in treatment of their own problems as they may be related to the child's. Keen interest in the possibilities of direct treatment of children and combined treatment of children and parents has been demonstrated in the past ten years and many modifications of the professional team approach have been made. The core of service at the Child Guidance Clinic of Waterbury is psychotherapy and this means a dynamic, intensive, psychoanalytically oriented psychotherapy. In plain words, this means much more than simple supportive or suggestive help to parents and child. It means much more than manipulation of the environment. It means a great deal more than "educating," "teaching," "lecturing" or "talking to" the individual parent, child or referring person. A definition of psychotherapy might be that psychotherapy is an emotional experience between two persons, one of whom is a patient and the other is the doctor who controls this relationship in such a way that the patient's emotional reactions to himself and to other people may be examined to the fullest extent, explored and modified. Psychotherapy can best be provided by a person who has himself had psychotherapy and has thereby discovered some of the problems in his own personality and has learned how to cope with them. This is not intended to minimize the importance of educational, diagnostic and consultative work nor is it intended to minimize the important role of the psychiatrist in forms of therapy other than psychotherapy. It takes all kinds of people to make up the world and it takes all kinds of psychiatrists to treat psychiatric illness.

Finally, a few words about the present program at the Child Guidance Clinic of Waterbury. Psychotherapy and has thereby discovered some of the treatment of the parents' problems as related to the child's will be the heart of the service. All other services grow out of the nuclear skill of the professional staff to do psychotherapy. Consultation to social agencies, consultation in certain instances to referring persons, educational services both to the general public and to certain professional groups will be offered as the need for these services becomes apparent and can be suitably balanced with the treatment service. The types of problems that are referred to us now are mainly of three kinds. First of all there is the neurotic child, usually with one or both parents being neurotic. These children very often have a great deal of obvious anxiety and fear-

fulness but they may also be the children who seem to be just a little bit withdrawn and shy and sensitive. They are often the children who have disturbances in their sleep or habits of elimination. They are the children who may have somatic manifestations such as tics or stomach aches, headaches, nausea and other symptoms which are found to be not organically based. In the second place, there are a great many children who have the so-called "behavior disorder." In the current APA classification we now call this group of disturbances the Transient Situational Personality Disturbance. There is a great deal of variety as to the degree of disturbance and the nature of the "transient" feature in these cases. Some of the behavior disorders are extremely hard to treat although, as a group, they respond more readily to concurrent treatment of parent and child than will the neurotic problem. In the third place, there are always a few psychotic children referred to the Clinic during a year and some of these can be treated in an outpatient setting but a number of them must be hospitalized. When hospitalization is necessary it is always difficult to help parents to accept referral to a State hospital and it will be a long time, unfortunately, before adequate residential treatment facilities for the emotionally disturbed child will be available in this State.

In connection with helping parents accept referral of the child to a hospital a word may be said at this time about referral to the Child Guidance Clinic. From time to time a referring person, such as a physician or clergyman, will express impatience and sometimes displeasure and dislike of the manner in which the Clinic prefers to work with parents. However, it is accepted practice in almost all Child Guidance Clinics for parents to call and make their own contact with the professional person at the Clinic who is taking responsibility for interviewing new referrals. Oftentimes this is the social worker but in some clinics this responsibility is shifted around. In the Waterbury clinic the social worker is given the responsibility for initial interviews with the parents, not for the purpose simply of obtaining a history in a cut and dried fashion, but for the purpose of helping the parent to begin the discussion of a difficulty that is bound to be painful for him. Parents should not have to wait long for their first interview and sometimes it can be scheduled within a week of their calling. The child will be seen at a later date and just at this present time there will not be any unnecessary delay. This is due to additional

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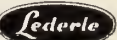
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staff time made possible by the State allocation referred to previously. A diagnostic study necessarily includes interviews with child and usually with both parents followed by a staff diagnostic conference at which time a plan for treatment or other recommendations is made. If treatment is recommended and accepted by the parents and if treatment time is available, there may be concurrent treatment of parents and child with different therapists on the staff. It may possibly develop that for a while the child is not going to be seen until the parent has had an opportunity for further work on her part of the problem. This team collaboration between the three professional members of the Clinic in dealing with different members of the same family is the kind of service that is so extremely hard to obtain in private psychiatry.

There are many other things that could be said about the details of Clinic operation, the reasons for certain policies and procedures, the techniques for psychotherapy, the psychological testing process, the training required for the three different professions. It is hoped that questions about any of these things will be asked the speaker in the discussion period that follows. It can be stated in summary concerning the present program of the Clinic that it meets the requirements of the American Association of Psychiatric Clinics for Children.

FUTURE 1956-1966

In looking ahead ten years from now, it is not out of the realm of possibility to visualize a Child Guidance Clinic in Waterbury which could provide not only service to those who need it but training experience in the fields of child psychiatry, psychiatric social work and clinical psychology. The American Association of Psychiatric Clinics for Children has special requirements for those clinics that wish to attain training status and these requirements are much more comprehensive than are the regular membership requirements. It seems idealistic, perhaps, to some physicians present here to talk about a clinic on so large a scale as this, but it is only a large, well organized, soundly financed and directed clinic that can attract and continue to hold professional persons in these three fields. Competition with clinics in medical centers and urban areas is high. Fortunately for the State of Connecticut, the Connecticut Association for Mental Health and the State Legislature have become increasingly interested in finding ways and means of providing service for all the people in the State so that the

relatively rural areas in Connecticut will not continue to be completely deprived of psychiatric services for children.

The future holds also the possibility of providing much more in the way of orientation experience for the general hospital resident. Orientation experience means development of awareness and understanding of the psychological aspects of medical practice. The purpose, of course, is to help the surgeon, the obstetrician, the pediatrician, the internist, all the doctors, to appreciate the importance of the patient-doctor relationship. Only recently have medical schools paid much attention to this aspect of medical training and the psychiatrist stands ready wherever possible and whenever opportunity arises to do what he can in this area.

Finally, a word might be said about the preventive aspects of the Child Guidance Clinic service. It is impossible to measure results of educational work with groups, even with small groups which are carefully selected and closely followed, but certainly this Clinic in Waterbury has an interest in doing whatever it can to promote the general mental health and well-being of the people of this community.

G.P. Academy Acts

The American Academy of General Practice, meeting in St. Louis in March, tightened its standards for membership. The Congress of Delegates adopted an amendment which now requires a one-year rotating internship as an absolute minimum requirement for membership.

The delegates also approved a new definition on general practice which was originally requested by three different AMA committees now studying general practice. The definition reads:

"General practice is that area of medical care performed by a doctor of medicine in those fields of diagnosis and therapy commensurate with his professional competence, assuming a total continuing responsibility for the health of the individual or the family as a unit."

A resolution calling for inclusion of physicians under Old Age and Survivors Insurance was rejected and instead the delegates urged continuation of Academy efforts to obtain passage of the Jenkins-Keogh bill, a voluntary retirement plan for professional persons.

NEWS FROM WASHINGTON

Defense Department Prepares Doctor Amendment to Draft Act

Defense Department, preparing for expiration of the special doctor draft act next June 30, is moving ahead with legislation to amend the regular draft act so that physicians may be called up selectively. The bill is now before the Budget Bureau, which is expected to clear it soon for presentation to Capitol Hill.

The proposed amendment would in effect waive the Selective Service Act's prohibition against discrimination to the extent that physicians, dentists and allied scientists could be called up by their professional classification. Thus these men, because they are in the particular professional groups, would be subject to special calls and not necessarily inducted in the same order as others in their same age group.

One phase of the situation that is causing some concern in the medical profession is the possibility that June 30 will see the end not only of the special doctor draft act, but also the expiration of the National Advisory Committee to Selective Service (the Rusk committee) and its affiliated volunteer state and local committees. The Defense Department Amendment setting up the new doctor procurement mechanism under the regular draft has no provision for continuing the committee. Selective Service had not recommended retaining the committee.

The national, state and local committees, made up of physicians and dentists, have been the liaison between the military services and Selective Service on the one hand and the medical professions and medical schools on the other.

Burney Appoints Physicians' Committee to Advise PHS

Surgeon General Burney has appointed a committee of seven physicians to advise him on U. S. Public Health Service activities related to the practice of medicine. In making the announcement Dr. Burney said:

"We have many groups advising us on research

and disease control. With growth of medical and related research, it is increasingly important that we work with private physicians as well as health agencies to help apply the new knowledge promptly and effectively. Our new committee will be of great aid in this and in advising on activities of PHS which bear directly or indirectly on the practice of medicine. We are very grateful to have the advice of this distinguished group of physicians."

Members of the new group, which held its first meeting April 4-5 in Washington, are: Drs. Hugh H. Hussey, Washington, D. C., and Julian Price, Florence, S. C., both trustees of the American Medical Association; Stuart Adler, Albuquerque, New Mexico; C. Byron Blaisdell, Asbury Park, New Jersey, a member of the AMA Committee on Legislation; W. L. Portteus, Franklin, Indiana, past president of the Indiana Medical Association; Stanley R. Truman of Oakland, California, former president of the American Academy of General Practice; and William B. Walsh, Washington, D. C., past president of the National Medical Veterans Society.

Staff Report on Medical Schools: Financing, Other Problems

A 479 page staff report on U. S. medical and other scientific schools has been issued by the House Interstate and Foreign Commerce Committee, in its first action in the health field since organization of the 85th Congress. Next step is introduction of the administration's bill for grants to medical, dental and osteopathic schools to construct classrooms. Chairman Oren Harris of the full committee said hearings on the bill would be held by the health subcommittee and headed by Rep. John Williams.

The report, which is based on questionnaires sent all professional schools, was authorized last July by the full committee, then headed by Rep. Percy Priest. (The report carries a dedication to Mr. Priest who died last fall.) Chairman Harris made clear that the report, which will serve as a background for the forthcoming hearings, is not a committee report.

Some of its highlights:

FEDERAL AID

All but a few of the 83 schools replying say they would apply for grants if federal aid were authorized. Their construction projects would cost \$400 million, about 60 per cent chargeable to teaching and 40 per cent to research. About 70 per cent of the total would be spent for new facilities, 20 per cent for expansion and 10 per cent for rehabilitation. All six osteopathic schools and 10 of the 11 public health schools said they would apply for federal money too.

MEDICAL SCHOOLS PRESENT AND FUTURE CAPACITY

Of about 15,000 applicants for admission to medical schools in the 1955-56 academic year, about one half were accepted, filling the freshmen classes to capacity. A sharp increase in the number of medical applicants is anticipated in the next 10 years. "The Association of American Medical Colleges has stated that while some existing schools with enlarged facilities might be able to accept additional students, increased capacity for the training of medical students must be brought about primarily by the establishment of new schools. In the absence of additional capacity, even beyond the expansion now underway, a substantially lower percentage of applicants is likely to gain admission to medical schools."

GRADUATES AND PHYSICIAN REQUIREMENTS

The ratio of 113 physicians for each 100,000 persons has been maintained in the past several years only through a steady increase in the number of foreign trained physicians. The number added to the profession in 1955 represented the equivalent of the number of graduates of approximately 10 United States medical schools. In 1955-56, hospitals reported close to 8,000 alien physicians training and serving in approved internships and residents, filling about 25 per cent of these posts. "During the last five years, the number of alien physicians serving in approved internship and residency positions in U. S. hospitals has increased 280 per cent, while over the same period the number of U. S. citizens serving in these positions . . . decreased 1 per cent."

FINANCIAL ASPECTS

While medical schools report wide variation in teaching costs (from just over \$1,000 to \$15,000), tuition income covers "a smaller and smaller percentage of total operating expenses. In 1956-57 it averaged only 18 per cent." In that same period

States contributed about \$52 million for the operation of 47 medical schools as against a total expenditure for all medical schools of \$111 million. "Thirteen States and the District of Columbia with a total civilian population of more than 19 million did not contribute any public funds."

Educators Differ on Army Granting Graduate Degrees

Some segments of higher education are opposing an Army-backed bill giving Walter Reed Army Institute of Research authority to award "master of science, master of public health, and doctors of science degrees in medicine, dentistry, veterinary medicine, and in the biological sciences involved in health services." The bill (HR3516) already had been reported favorably by the Kilday subcommittee of the House Armed Services Committee following hearings. Then the subcommittee decided to reconsider after receiving several protests, including one from Dr. Nathan Pusey, president of Harvard University, who wrote that enactment "will surely debase the established academic currency of all American universities."

At a rehearing March 14, the subcommittee heard from Dr. Ward Darley, who is executive director of the Association of American Medical Colleges but who spoke on behalf of the American Council of Education. He objected on the broad principle that no federal agency "standing alone" should be authorized to move into the field of higher education and grant graduate degrees. He also read a statement from T. Keith Glennan, president, Case Institute of Technology, who headed the council committee that had looked into the Walter Reed issue and had opposed the plan.

Supporting the Army were Dr. William Stone, dean, University of Maryland Medical School, and Dr. Colin MacLeod, professor of research medicine, University of Pennsylvania. They maintained the bill was designed, among other things, to attract more men into military medical careers and to supply advanced training in preventive medicine that regular institutions do not readily offer.

Eight PHS Promotions Announced

Eight promotions in the commissioned corps of the Public Health Service have been announced by Surgeon General Leroy Burney. Three who are advanced to rank of major general are Drs. David

E. Price, who will fill a newly created post of deputy chief of the Bureau of Medical Service; Theodore J. Bauer, deputy chief of the Bureau of State Services, and C. J. Van Slyke, associate director of the National Institutes of Health.

Five others named as brigadier generals are: Drs. Robert J. Anderson, chief, Communicable Disease Center, Atlanta; Albert J. Chapman, chief, division of special health services, Bureau of State Services; Roderick Heller, director of National Cancer Institute; Robert J. Felix, director, National Institute of Mental Health, and John D. Porterfield, assistant surgeon general in the office of the surgeon general.

Budget Bureau Testifies on Veterans' Medical Problems

Because Veterans Administration hospital facilities now are adequate to take care of all service-connected cases, the Bureau of the Budget does not believe new hospitals should be constructed when they would be solely for nonservice-connected cases. This was one of the views expressed to the House Veterans Affairs Committee by Robert E. Merriam, assistant budget director. He was accompanied by Fred McNamara, deputy chief of the bureau's labor and welfare division.

Under present law, Mr. Merriam pointed out, nonservice-connected cases may be hospitalized when beds are available, and he believes an act of Congress would be required to change the policy. He said VA expects the number of service-connected cases will remain at about 40,000, but that nonservice cases make up two-thirds of the total receiving VA care. In his opinion, there are three possible solutions to the problem: (1) VA to take care of all nonservice cases, or (2) deny care to all such cases, or (3) set up a program somewhere between the two extremes. He said he hoped Congress would set a bed ceiling for VA, the present ceiling is 125,000, but it was set by the administration, not Congress.

Testimony of the Budget Bureau representatives concluded the committee's hearing, which has considered various VA problems with emphasis on a bill by Chairman Olin Teague (D-Texas) to tighten up restrictions on admission of nonservice cases. Discussing the bill, Mr. Merriam said he believes it solves some of the problems, but that the committee also might want to make it possible for the government to "go behind" the veteran's statement

that he cannot afford to pay for hospital care in a nonservice case. Under present law, or interpretation of law, the veteran's statement that he can't afford to pay may not be further investigated. Mr. Merriam said Congress might make the requirement for treatment of a nonservice case the same test as for a VA pension, or establish a means test of the veteran's financial situation.

VA Approves Changes in "Intermediary" Home-Town System

It is neither the desire nor the intention of Veterans Administration to eliminate the "intermediary" system for administering the home-town care program, an arrangement in which a third party (a State medical agency) receives billings and makes payments. This was the gist of a statement by VA's chief medical director, Dr. William S. Middleton, at a Washington meeting attended by representatives of eight States and Hawaii, where the "intermediary" system remains in effect. Also present were representatives of the AMA's Washington Office and the national Blue Shield. Dr. Middleton said he felt sure that by mutual consideration of the problems involved agreement could be reached that would be acceptable to all. It was decided that contracts would be continued, based on the following major points:

1. Contracts uniform for the eight States and Hawaii, and generally modeled on the Michigan State plan.
2. Authorization for extended care treatment to be made by VA, with a copy of the authorization going to the contractor.
3. Contractors to continue their audits and receive invoices (doctors' monthly bills) with medical reports.
4. Physicians' summary reports, generally quarterly, to go directly to VA.

House in Spirited Debate on Labor-HEW Appropriations

Anid charges of "phony cuts" and "irresponsibility," the House debate on the combined Labor Department and Health, Education, and Welfare Department stirred up members to a high pitch. Tentative cuts have been made in the Labor portion of the bill, and members of the Appropriations subcommittee that reported out a \$2.48 billion HEW

appropriation braced themselves for cuts in the health field. They seemed to have reason for worry; the first important HEW item 2, the Food and Drug Administration's fund, was cut 1.3 million.

Rep. John Fogarty (D-Rhode Island), subcommittee chairman commented: ". . . this is the most difficult appropriation bill to cut because it deals mainly and directly with the problem of human beings. Most of the huge expenditures . . . are uncontrollable . . . members of this House in previous Congresses have by your votes bound us in actions as far as appropriating funds in many of the grant areas." He argued that 91 per cent of the HEW budget was for uncontrollable grants.

The Rhode Island Congressman argued that budget cuts of any significance can only be brought about by repeal of some legislation. Rep. Howard Smith (D-Virginia) maintained on the other hand that ". . . there is not a bill that comes before this House that could not be cut 10 per cent . . ." Mr. Fogarty has served notice that he will demand roll call votes on all cuts when the bill comes up for final approval.

House Sponsors of Health Bills Heard

Nearly a score of House members testified or filed statements with the House Interstate subcommittee on health in support of their health bills. The traditional "sponsors day" was held March 28 and 29 before the group headed by Rep. John Bell Williams (D-Mississippi). The subcommittee later decides what priority to give the bills. The five members present showed considerable interest in such proposals as establishment of loan provisions in the Hill-Burton hospital construction grant act, federal controls on chemical additives to food and cosmetics, and restrictions on health and accident insurance sales in interstate commerce. Rep. Poage (D-Texas) outlined his bill (HR1979) for up to \$50 million in loans to groups that do not want federal grants for hospital construction, but want loans.

Control to be Sought on Treatment Devices

Food and Drug Administration is drafting a bill, which it will ask Congress to pass, requiring safety testing of treatment devices before they may be placed in interstate commerce. The proposed amendment would, in effect, do for devices what the law already demands of manufacturers of new drugs.

Social Work Dean Heads Children's Bureau

Katherine Brownell Oettinger, who has been active in social work for 30 years, will head the U. S. Children's Bureau, provided the Senate, as expected, approves the Presidential nomination. Mrs. Oettinger, dean of the school of social work at Boston University, received her master's degree from Smith in 1926 and has held posts in social work in Pennsylvania and New York.

Auto Makers Urged to Work for Safety

Manufacturers are the only ones who can incorporate safety factors into autos, and if they don't do so Congress should act to force them. This in essence was the testimony of a representative of the Michigan State Medical Society, appearing before a special safety subcommittee of the House Interstate and Foreign Commerce Committee. Dr. John D. Rogers, the Michigan witness, also cited a recommendation of the AMA House of Delegates, adopted December, 1955, which urged Congress to authorize a national body to approve and regulate auto safety standards.

Miscellany

Dr. C. Williard Camalier of Washington, D. C., for years a leader in national dental affairs, has been awarded honorary membership in the New York Academy of Dentistry, an honor that has gone to only two others in the long history of the organization. . . . The number one project of Disabled American Veterans is a "good—and I mean really good—compensation increase bill" according to DAV testimony before the House Veterans Affairs Committee. . . . Rep. Reuss (D-Wisconsin) proposes that self employed physicians and dentists be allowed to participate in the federal Old Age and Survivors Insurance program on a voluntary basis; once they entered they could not withdraw. The bill is HR4824. . . . Thirteen States have benefitted from the new law donating federal surplus property for civil defense.

Senator Hubert H. Humphrey (D-Minnesota) has filed S1487, extending Hill-Burton Hospital Construction Act for three more years, until June, 1962. In his explanatory statement, in which he gave population growth as one of the factors of justification, Senator Humphrey also urged Congress to appropriate the maximum authorized amount of \$210 million as Federal contribution toward hospital expansion this year.



HEALTH TODAY

This brochure tells the dramatic story of health progress—a 50 per cent reduction in the general death rate an increase of 21 years in life expectancy at birth and other important contributions made possible by medical advances.

This AMA publication and two others which contain useful health information are available in quantity, without charge. They may be used as mail enclosures, reception room information pieces and for community meetings.

The full series or individual leaflets may be obtained by filling out and mailing the order blank on this page.

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please send me without charge the following leaflets in quantities indicated:

- | | | |
|--|-------|--------|
| HEALTH TODAY (medical progress) | _____ | copies |
| ON GUARD (AMA evaluation of drugs) | _____ | copies |
| WHY WAIT? (the role of the family physician) | _____ | copies |

NAME

Office Address

.....

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

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First Complete Alumni Fund and AMEF Report

Connecticut physicians and members of the Woman's Auxiliary to the State Medical Society contributed a total of \$57,067 to medical schools in 1956, making it a record year.

A report recently released by the American Medical Education Foundation indicates that gifts to alumni funds by 1,184 physicians comprised \$36,272 of total contributions, while the Woman's Auxiliary gave \$2,130 to the 1956 Connecticut AMEF Campaign and 916 physicians contributed \$18,665.

Whereas Connecticut achieved sixth place as to number and amount of contributions in the 1956 AMEF Campaign, the new report combines this with alumni fund donations and this moves Connecticut to eighth place. California took first place with 17,838 physicians contributing \$537,521 as assessments and in the same type of program 10,174 Illinois physicians contributed \$333,198 to give their State third place. Second place was taken by New York, \$367,573 from 10,071 contributors. Other leading States were Pennsylvania \$295,358—6,994 contributors; Ohio \$141,252—3,122 contributors; and Texas \$94,574—2,258 contributors.

The total national contribution, including \$225,000 from the American Medical Association, reached \$3,320,152, the highest on record, and this represented an AMEF total of \$1,072,727 (39,892 contributors) and \$2,247,425 in alumni fund donations (44,765 contributors).

Plainville Physicians Organize First Medical Society and Announce Community Services

"This growing community took a giant step forward yesterday and made plans to make an even more important move in the future.

"The actions involved the doctors, who formu-

lated the first Plainville Medical Society, and the selectmen, who agreed to initiate a study into a possible change in the form of town government."

In these words the *New Britain Herald* on March 15 recognized the active interest of practicing physicians in community affairs. And the six physicians in Plainville demonstrated by the action how to organize for community medical leadership even though there are only a few physicians to meet the responsibility.

Dr. Lawrence H. Frost was elected first president of the new organization. He is president of the Plainville Hospital Association and a member of the medical staff at Bristol Hospital. Other officers elected were Dr. George F. Cook, town health director, vice-president; Dr. Joseph A. Menousek, secretary; and Dr. Aresto P. Tortolani, treasurer.

Voice and personality were given to the new society by an announcement that its first action would be organization of an emergency medical plan for the community.

Dr. Frost said the Society will afford the town better service and will be available to advise the Town Health Council, organized about three months ago.

He commented that formation of the society shows that the physicians are interested not only in their own patients but in the welfare of the town in general.

Life Span Featured During Medical Education Week

"His Cake May Have 70 Candles Someday," was the caption of an institutional advertisement sponsored by the State Medical Society and Connecticut Medical Service for publication in daily newspapers during Medical Education Week, April 21-27.

The advertisement carried an illustration of a birthday party for a seven-year old boy and explained the copy theme by the statement: "This American

boy and his playmates can look ahead to 70 birthdays—their life expectancy is 20 years more than in 1900.” The message went on to explain how medical education and research have played a major role in increasing the American life span, told of advances in preventive medicine and the activities of the 82 medical schools in the United States, and concluded: “Physicians at the schools also conduct courses for doctors in practice—and this means new knowledge and skill to benefit patients everywhere.”

Readers were offered a free copy of an informative booklet “What’s Up With Our Medical Schools” through use of a coupon appearing in the advertisement.

Prints of the advertisement were furnished for display on bulletin boards at 50 hospitals and 142 high schools throughout the State. The illustration and message were also revised for use by television stations.

Connecticut TV Committee Presents Career Series

The third in a series of television programs on “Careers in Health” will be sponsored by the Connecticut TV Committee for Health Education, Saturday, May 11, 4:30 P. M.

To be televised from the studios of WHCT, Hartford, Channel 18, the program will depict the varied careers open to nurses, technicians and other trained hospital personnel.

Two previous programs presented careers in public health and rehabilitation services and outlined the growing scope of the more than 150 careers which have been strengthened or newly created by medical progress.

The three programs were planned to attract audiences of young people and parents to acquaint them with the shortages of personnel in health work and the resultant increase in career opportunities.

The Television Committee, now in its third year of operation, is composed of 18 representatives from the State Department of Health, the State Medical Society, leading statewide health agencies, and four television stations. All programs are presented as a public service in cooperation with the television stations.

New AMA Service for Local Television

A new television service—film clips for use on news programs—was initiated in March by the American Medical Association.

Mailed to a key list of 215 stations, a film report on medical aspects of drunken driving was used on 88 different news programs over a period of two weeks. During April a three-minute film feature on medical education will be sent to the same stations and in June all stations will receive a film excerpt from the inaugural address of Dr. David B. Allman when he assumes office as AMA president. Other news films are scheduled for production later in the year.

Transatlantic Hook-Up to Commemorate William Harvey

Two of the world’s great medical confraternities—the physicians of the United States and the United Kingdom—will be linked across the Atlantic via the new underseas cable on Wednesday, June 5. Thus, for the first time in history, two medical conventions on different continents will be in direct, two-way communication.

Arranged by Smith, Kline & French Laboratories, Philadelphia pharmaceutical manufacturers, the hook-up will join the American Medical Association, then in annual session in New York, and the Harvey Tercentenary Congress, convened in London to commemorate the 300th anniversary of the death of William Harvey, the English physiologist who first described the circulation of the blood.

Fittingly, doctors both in New York’s Carnegie Hall and London’s venerable Great Hall of the Royal College of Surgeons will discuss: “The Results of Cardiac Surgery.”

Invitations will be sent members of the medical profession to attend the Carnegie Hall portion of the meeting, which gets underway at 10:15 A. M. (E.D.T.).

In New York, the participants will include Drs. Michael E. De Bakey, Baylor University, chairman of the American panel; Alfred Blalock, Johns Hopkins University; John H. Gibbon, Jr., Jefferson Medical College; Frank L. A. Gerbode, Stanford University, and George E. Burch, Tulane University.

In London, Sir Clement Price-Thomas of West-

minister Hospital will head an international panel including Sir Russell Brock, Guy's Hospital, London; Professor G. d'Allaines, Paris, and Dr. Maurice Campbell, also of Guy's Hospital.

Immediately before the opening of the transatlantic cable link, the New York panel will summarize for the AMA audience four papers which will have been presented by the London panelists.

With the opening of the link, the inter-continental roundtable will discuss, back and forth across the Atlantic for more than an hour, the findings of the Harvey participants.

In a cable to A. Dickson Wright, president of the Harvey Tercentenary Congress, Dr. George F. Lull, Secretary-General Manager of the AMA, wrote:

"The contribution to medical science by William Harvey is recognized by medical men throughout the world. The fitting tribute which will be paid him in London on the 300th anniversary of his death is of great interest to this association. Accordingly, the American Medical Association desires, if possible, that a portion of the Tercentenary Congress be carried by trans-Atlantic cable to its members at their annual meeting convening in New York June 3-7."

Wright cabled in reply:

"The organising committee of the Harvey Tercentenary Congress is honoured by the desire of the American Medical Association to participate in the commemoration of William Harvey, and through the courtesy of Smith, Kline & French Laboratories the symposium on the results of cardiac surgery will be carried to New York . . . thus establishing medical history and the world-wide tribute to William Harvey."

Smith, Kline & French Laboratories noted that the trans-Atlantic hook-up is part of its program to foster the "person-to-person" relationship between doctors all over the world, urged last fall by President Eisenhower.

Coincidental with the trans-Atlantic conference, a crew of the SKF Medical Color Television Unit will be in Britain to provide closed-circuit medical television for doctors there. The five medical conventions to be televised—including portions of the Harvey Tercentenary Congress—will mark the first time the SKF unit, the only one of its kind, has visited the United Kingdom. The tour has the approval of the U. S. State Department.

SKF said the British schedule will not interfere with plans to televise surgical and clinical presentations at the State Medical Society of Wisconsin convention in Milwaukee, May 7-9; the American Medical Association meeting, or the Canadian Medical Association convention, June 17-20.

Use of X-rays and Other Ionizing Radiation

STATEMENT BY THE UNITED NATIONS SCIENTIFIC COMMITTEE ON THE EFFECTS OF ATOMIC RADIATION CALLING ATTENTION TO THE RESPONSIBILITIES OF THE MEDICAL PROFESSION

1. The United Nations General Assembly, being aware of the problems in public health that are created by the development of atomic energy, established a Scientific Committee on the Effects of Atomic Radiation. This Committee has considered that one of its most urgent tasks was to collect as much information as possible on the amount of radiation to which man is exposed today, and on the effects of this radiation. Since it has become evident that radiation due to diagnostic radiology and to radiotherapy constitutes a substantial proportion of the total radiation received by the human race, the Committee considers it desirable to draw attention to information that has been obtained on this subject.

2. Modern medicine has contributed to the control of many diseases and has substantially prolonged the span of human life. These results have depended in part on the use of radiation in the detection, diagnosis and treatment of disease. There are, however, few examples of scientific progress that are not attended by some disadvantages, however slight. It is desirable therefore to review objectively the possible present or future consequences of increased irradiation of populations which result from these medical applications of radiation.

3. It is now accepted that the irradiation of human beings, and particularly of their germinal tissues, has certain undesirable effects. While many of the somatic effects of radiation may be reversible, germinal irradiation normally has an irreversible and therefore cumulative effect. Any irradiation of the germinal tissues, however slight, thus involves genetic damage which may be small but is nevertheless real. For somatic effects there may, however, be thresholds for any irreversible effects, although if so these thresholds may well be low.

4. The information so far available indicates that the human race is subjected to natural radiation,¹ as well as to artificial radiation due to its medical applications, to atomic industry and its effluents and to the radioactive fall-out from nuclear explosions. The Committee is aware of the potential hazards that such radiation involves, and it is collecting and examining information on these subjects.

5. The amount of radiation received by the population for medical purposes is now, in certain countries, the main source of artificial radiation and is probably about equal to that from all natural sources. Moreover, since it is given on medical advice, the medical profession exercises responsibility in its use.

6. The Committee appreciates fully the importance and value of the correct medical use of radiation, both in the diagnosis of a large number of conditions, in the treatment of many such diseases as cancer, in the early mass detection of conditions such as pulmonary tuberculosis, and in the extension of medical knowledge.

7. Moreover, it appreciates fully the contribution of the radiological profession, through the International Commission on Radiological Protection² in recommending maximum permissible levels of irradiation. As regards those whose occupation exposes them to radiation, the establishment of these levels depends on the view that there are doses which, according to present knowledge, do not cause any appreciable body injury in the irradiated individual; and also on the consideration that the number of people concerned is sufficiently small for the genetic repercussions upon the population as a whole to be slight. Whenever exposure of the whole population is involved, however, it is considered prudent to limit the dose of radiation received by germinal tissue from all artificial sources to an amount of the order of that received from the natural background radiation.

8. It appears most important therefore that medical irradiations of any form should be restricted to those which are of value and importance, either in investigation or in treatment, so that the irradiation of the population may be minimized without any impairment of the efficient medical use of radiation.

9. The Committee is consequently anxious to receive information through appropriate governmental channels as to the methods and the extent by which such economy in the medical use of radiation can be achieved, both by avoiding exam-

inations which are not clearly indicated and by decreasing the exposure to radiation during examinations, particularly if the gonads, or the foetus during pregnancy lie in the direct beam of radiation. It seeks, in particular, to obtain information as to the reduction in radiation of the population which might be achieved by improvements in instrument design, by fuller training of personnel, by local shielding of the gonads, by choosing appropriately between radiography and fluoroscopy, and by better administrative arrangements to avoid any necessary repetition of identical examinations.

10. The Committee also seeks the cooperation of the medical profession to make possible an estimate of the total radiation received by the germinal tissue of the population before and during the child-bearing age. It considers it to be essential that standardized methods of measurement, of types at present available, should be widely used to obtain this information and it emphasizes the value of adequate records, maintained by those using radiation medically, by the dental profession, and by the responsible organizations in allowing such radiation exposure to be evaluated. The Committee is convinced that information of this type will make it possible to decrease the total medical irradiation of the population while preserving and increasing the true value of the medical uses of radiation.

1. The radiation due to natural sources has been estimated to cause between 70 and 170 millirem of irradiation to the gonads per annum in most parts of certain countries in which it has been studied, although higher values are found locally in some areas. See the reports "The hazards of man to nuclear and allied radiations" published by the United Kingdom Medical Research Council in June, 1956, in which also the millirem is defined; and from information submitted to the Committee.

2. See the report of the International Commission on Radiological Protection (published in the *British Journal of Radiology*—Supp. 6, of December, 1954—in the *Journal français d'électro-radiologie*—No. 10, of October, 1955—etc. and revised in 1956).

Motion Sickness

An Army study of 26 drugs for seasickness has shown that Marezine, Bonamine, and Phenergan are the most effective. For airplane sickness the two former were found best. Dramamine is also effective against sea and air sickness, while Trimeton is good for air sickness. Take them one half hour before departure for maximum effect.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1956-1957

REPORT OF THE TREASURER

The financial statements prepared by Seward and Monde, auditors of the Society, are printed in entirety in the agenda. These statements are respectfully submitted as the report of the Treasurer.

Frank H. Couch

MEMBERSHIP REPORT OF THE SECRETARY

FAIRFIELD COUNTY

Membership—January 1, 1956.....	778
New Members	37
Less:	
Deaths	12
Resignations, transfers	12
Non-payment dues, etc.	8 32
	—
Net Gain	5
Membership—December 31, 1956.....	783

HARTFORD COUNTY

Membership—January 1, 1956.....	910
New Members	37
Less:	
Deaths	11
Resignations, transfers	16
Non-payment dues, etc.	2 29
	—
Net Gain	8
Membership—December 31, 1956.....	918

LITCHFIELD COUNTY

Membership—January 1, 1956.....	128
New Members	9
Less:	
Deaths	3
Resignations, transfers	4
Non-payment dues, etc.	0 7
	—
Net Gain	2
Membership—December 31, 1956.....	130

MIDDLESEX COUNTY

Membership—January 1, 1956.....	103
New Members	10
Less:	
Deaths	1
Resignations, transfers	3
Non-payment dues, etc.	2 6
	—
Net Gain	4
Membership—December 31, 1956.....	107

NEW HAVEN COUNTY

Membership—January 1, 1956.....	880
New Members	53
Less:	
Deaths	13
Resignations, transfers	25
Non-payment dues, etc.	3 41
	—
Net Gain	12
Membership—December 31, 1956.....	892

NEW LONDON COUNTY

Membership—January 1, 1956.....	167
New Members	12
Less:	
Deaths	1
Resignations, transfers	2
Non-payment dues, etc.	2 5
	—
Net Gain	7
Membership—December 31, 1956.....	174

TOLLAND COUNTY

Membership—January 1, 1956.....	20
New Members	1
Less:	
Deaths	1
Resignations, transfers	0
Non-payment dues, etc.	0 1
	—
Net Gain	0
Membership—December 31, 1956.....	20

WINDHAM COUNTY

Membership—January 1, 1956.....	62
New Members	5
Less:	
Deaths	1
Resignations, transfers	2
Non-payment dues, etc.	0 3
	—
Net Gain	2
Membership—December 31, 1956.....	64

ASSOCIATE MEMBERS

January 1, 1956.....	11
Less Deaths	0
	—
Associate Members—December 31, 1956.....	11

Total Society Membership—January 1, 1956.....	3,048
New Members	164
	—
Total Membership—December 31, 1956.....	3,212

Less:	
Deaths	43
Resignations, transfers	64
Non-payment dues, etc.	17
	— 124
TOTAL SOCIETY MEMBERSHIP—December 31, 1956.....	3,088
Net Gain for year.....	40
TOTALS	
Fairfield	783
Hartford	918
Litchfield	130
Middlesex	107
New Haven	892
New London	174
Tolland	20
Windham	64
	3,088
Associate Members	11
	3,099

REPORT OF THE MANAGING EDITOR OF JOURNAL

In reviewing the year 1956 certain facts are of particular note and will be commented upon herewith. The problem of securing suitable material for the Progress in Clinical Medicine section has been a real one as evidenced by the fact that this section of the JOURNAL functioned in only five of the twelve issues and of these five manuscripts only three were produced by our own members. This situation at the present time appears more hopeful with sufficient material on hand for several issues.

At the request of the Editorial Board the number of editorials in each issue was reduced, resulting in an average of 4.4 per issue. Letters to the Editor have increased but not in sufficient numbers to create a real forum of discussion. News from County Associations have been combined with other news items of local and State interest in a section entitled Around the State.

The Convention Issue as usual carried pictures of the principal speakers in addition to the program of the annual meeting. Following the custom of previous years, the managing editor contributed a short historical article for this issue on Hamden, the host city for the annual meeting of the Society.

The death of one of our most beloved members, James Douglas Gold, was recognized in the August issue, dedicated to him. This number contained tributes by some of his conferees and several papers from the field of his chosen specialty, dermatology. Initial publication of two of these manuscripts was released to the JOURNAL through the kindness of the editor of the *Journal of the American Medical Association* and the editor of *Archives of Dermatology*. Our own members supplied four of the dermatological papers.

The Historian's Note Book appeared in all but two issues during the year, six of the articles being supplied by one author, Arthur S. Brackett of Riverside, formerly of Bristol. Eight insurance articles were published as well as four special articles. Scientific manuscripts by Connecticut physicians numbered 56 and by those outside Connecticut, 25. The activities of the Council were reported each month, also the reports presented before the House of Delegates. The reports from the two meetings of the American Medical Association House of Delegates were compiled by the managing editor and comments on the scientific meetings and exhibits of the Seattle session were written by one of the alternate delegates from Connecticut, Benjamin V. White.

The activities of the Connecticut Committee on Foods, Drugs, Cosmetics and Devices have appeared from time to time. The Committee to Study Maternal Mortality and Morbidity made two contributions during the year, and the sessions of the World Medical Association in Vienna were ably commented on by two of our members in attendance, Alfred Labensky and John H. Foster.

The JOURNAL continues to cost the Society a little over one dollar per member. This is necessary if the quality of the product is to be maintained. It is true that our advertising has increased in quantity and in financial returns but with this has come a corresponding increase in publication costs. It has been necessary to increase the size of the JOURNAL in order to maintain a proper balance between editorial content and advertisements and this of itself has utilized a major portion of the increased funds realized from advertising.

It is fitting that this report should end with an expression of appreciation. The Editorial Board and the literary editor are becoming increasingly helpful. Mrs. Feriola in the JOURNAL office demonstrates her value to our Society by her faithful attention to the many details of operation. The secretary, Dr. Barker, has been most helpful by supplying material and a frequent editorial of timely nature. The May issue of the JOURNAL in its final form was quite a shock to the managing editor for it was literally true that this was the first time in its 20 year history that the JOURNAL carried anything without the knowledge of the managing editor. Dr. Barker and I were highly honored and of more value to both of us, I am sure, is the spirit which motivated such an act, rather than the concrete evidence of such appreciation which continues to confront us almost daily.

Osler's epitome is worthy of repetition. "The artistic sense of perfection in work is another much-to-be-desired quality to be cultivated. No matter how trifling the matter on hand, do it with a feeling that it demands the best that is in you, and when done look it over with a critical eye, not sparing a strict judgment of yourself."

Respectfully submitted,
Stanley B. Weld

REPORT OF THE EDITORIAL BOARD OF THE CONNECTICUT STATE MEDICAL JOURNAL

H. M. Marvin, Chairman

Frederick A. Beardsley	Marshall Pease
Gerald J. Carroll	Charles H. Peckham
Hugh J. Caven	Clair Rankin
Frederick C. Gevalt, Jr.	Allan J. Ryan
Mark A. Hayes	Michael S. Shea
William H. Horton	Mark Thumin
Samuel D. Kushlan	Stanley B. Weld

For most of the past year the Editorial Board has had its full number of fifteen members, who represent most of the special fields of medicine and most of the geographic sections of the State. Several meetings have been held, each lasting for three or more hours and each characterized by a fine spirit of enthusiasm and cooperation. It is gratifying that members of the Board have expressed willingness, and even eagerness, to participate more fully in procuring and editing manuscripts and in the preparation of editorials.

Many practical suggestions have been offered and discussed; some have been accepted and the results will become apparent in due course. Constant attempts are being made to shorten the interval between the receipt of a manuscript and the final decision as to its acceptance or rejection. The section on Progress in Clinical Medicine has aroused great interest among both contributors and readers; already a number of superlative articles have appeared in this section, and others of equal merit will be published later this year.

The members of the Board believe that we are singularly fortunate in having Dr. Stanley B. Weld as the enthusiastic, untiring, devoted Managing Editor. We look to the coming years with full confidence that the JOURNAL will be one of which Connecticut physicians can be increasingly proud.

Respectfully submitted,
H. M. Marvin

Seward and Monde Certified Public Accountants

205 Church Street

New Haven 10, Connecticut

The Connecticut State Medical Society
New Haven, Connecticut

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1956 and the related statements of income and surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society, and without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence by methods and to the extent we deemed appropriate.

General Fund:

Cash in banks, reconciled and confirmed by direct correspondence with the depositories, is accounted for as follows:

Commercial accounts:

The Second National Bank and Trust Company—Journal Collections	\$ 5,519.68
The Second National Bank and Trust Company—Journal revolving fund...	4,000.00
The Second National Bank and Trust Company—Secretary's office revolving fund	4,000.00
The Second National Bank, Trust Department:	
Income cash account.....	6,779.13
Principal cash account.....	74.29
	<u>\$20,373.10</u>

Savings accounts:

Connecticut Savings Bank of New Haven	\$10,300.00
New Haven Savings Bank of New Haven	5,688.25
National Savings Bank of New Haven	10,530.39
Chelsea Savings Bank of Norwich.....	273.81
	<u>26,792.45</u>
Total	<u>\$47,165.55</u>

The Second National Bank of New Haven confirmed directly to us that as of December 31, 1956 they held the following securities as agent for the Treasurer of The Connecticut State Medical Society:

United States Treasury Bonds:

FACE VALUE	RATE AND MATURITY	BOOK VALUE	MARKET VALUE
\$2,000	2 7/8 % 1957	\$2,000.00	\$1,998.12
7,000	2 1/2 % 1969	6,795.73	6,203.75
5,000	2 1/2 % 1970	5,000.00	4,425.00
3,000	2 1/2 % 1971	2,979.11	2,655.00

Province of Canada Bonds:

3,000 Province of Nova Scotia 3 3/4 % Deb. due March 15, 1964.....	2,988.70	2,835.00
3,000 Province of Saskatchewan 3 1/8 % due February 1, 1966	3,021.60	2,677.50

Stocks:

50 shares Celanese Corp. of Amer. Ser. A 4 1/2 % cumulative preferred	5,181.25	3,300.00
Total	<u>\$27,966.44</u>	<u>\$24,094.37</u>

Dues receivable of \$1,610 are segregated by counties as follows:

COUNTY	AMOUNT
Fairfield	\$ 336
Litchfield	28
Middlesex	28
New London	56
Hartford	826
New Haven	336
Tolland	
Windham	
Total	<u>\$1,610</u>

ANNUAL REPORTS

Accounts receivable—journal of \$5,829.91 is due from advertisers.

Accounts payable—journal of \$247.42 represents amounts due for office supplies and printing expenses in connection with reprints.

The following is a comparison of budgeted and actual general expenses:

	BUDGET	ACTUAL	ACTUAL OVER OR (UNDER) BUDGET
Secretary's office	\$30,565.32	\$29,992.80	(\$ 572.52)
Treasurer's office	5,845.00	5,445.39	(399.61)
General and contingent	10,975.00	11,391.71	416.71
Public relations	17,435.00	16,390.04	(1,044.96)
Committee allotments	4,250.00	2,584.79	(1,665.21)
Building maintenance....	7,610.00	8,092.59	482.59
Journal	39,165.00	45,795.75	6,630.75
Total	\$115,845.32	\$119,693.07	\$3,847.75

Annual Meeting Fund:

Cash was confirmed directly.

Gurdon W. Russell Fund:

Cash was confirmed by direct correspondence and the Second National Bank of New Haven confirmed directly to us that as of December 31, 1956 they held the following fund securities as Agent for the Treasurer of the Connecticut State Medical Society:

FACE VALUE	BOOK VALUE	MARKET VALUE
\$691.12 New York, New Haven and Hartford Railroad Co. 4%—due 2007....	458.00	\$ 397.39
\$985.61 New York, New Haven and Hartford Railroad Co. 4½%—due 2022	338.00	478.02
\$523.27 New York, New Haven and Hartford Railroad Co. 5% conv. pfd. stk.—Series A	134.00	177.91
\$1,000.00 Boston and Albany Railroad Company, 4¼% improvement bonds, due August 1, 1978.....	820.00	740.00
\$5,000.00 U. S. Treasury bonds, 2¼% due 1959	5,000.00	4,829.68
Totals	\$6,750.00	\$6,623.00

O. C. Smith Fund:

We confirmed the principal and income cash by direct correspondence.

Building Fund:

Cash of \$10,064.90 was confirmed to us by the Second National Bank of New Haven.

Capital expenditures during the year in connection with the Society's new building addition are summarized as follows:

Balance in building and equipment account,
January 1, 1956.....\$ 81,253.57

Add, Current year additions:

New building addition.....	\$52,643.27
Building equipment for new addition	5,002.51
	<u>57,645.78</u>

Balance in building and equipment account,

December 31, 1956.....\$138,899.35

During the year funds have been transferred from the general funds to the funded reserve for depreciation. Cash of \$10,678.27 on deposit in the Connecticut Savings Bank was confirmed directly.

Clinical Congress:

Cash was confirmed directly by the depositories.

General:

The secretary's office has acted as collection agent for The American Medical Association's dues for the year 1956. At December 31, 1956 all collections to that date had been remitted to The American Medical Association.

In our opinion, the accompanying balance sheet and statements of income and surplus present fairly the position of The Connecticut State Medical Society at December 31, 1956, and the results of its operations for the year, in conformity with general accepted accounting principles applied on a basis consistent with that of the preceding year.

SEWARD & MONDE,

Certified Public Accountants

New Haven, Connecticut

March 25, 1957

Balance Sheet, December 31, 1956

GENERAL FUND

ASSETS

Cash	\$ 47,165.55
Investments (Market value \$24,094.37)	27,966.44
Dues receivable—1956	1,610.00
Accounts receivable—Journal	5,829.91
Automobile emblems on hand.....	9.00
Prepaid insurance	905.31
Total	<u>\$83,486.21</u>

LIABILITIES

Accounts payable:	
Journal	\$ 247.42
Accrued commissions—1956 dues.....	3.50
Surplus	83,235.29
Total	<u>\$83,486.21</u>

ANNUAL MEETING FUND

ASSETS

Cash	\$ 4,371.38
Prepaid expenses—1957 annual meeting.....	14.66
Total	<u>\$ 4,386.04</u>

LIABILITIES

Surplus	\$ 4,386.04
Total	\$ 4,386.04

SPECIAL FUNDS

ASSETS

Gurdon W. Russell Fund:	
Cash	\$ 116.75
Investments (market value \$6,623)....	6,750.00
	<u>\$ 6,866.75</u>
O. C. Smith Trust Fund:	
Principal cash	\$ 1,000.00
Income cash	304.67
	<u>1,304.67</u>
Building Fund:	
Cash	\$ 10,064.90
Land	12,270.31
Building and equipment.....	138,899.35
	<u>\$161,234.56</u>
Cash-savings account (funded re- serve for depreciation).....	10,678.27
	<u>171,912.83</u>
Clinical Congress:	
Cash	3,239.22
	<u>\$183,323.47</u>
Total	<u>\$271,195.72</u>

LIABILITIES

Gurdon W. Russell Fund—capital	\$ 6,866.75
O. C. Smith Trust Fund—capital.....	1,304.67
Building Fund:	
Reserve for depreciation.....	\$ 10,678.27
Capital	161,234.56
	<u>171,912.83</u>
Accounts payable	\$ 73.89
Clinical Congress—capital	3,165.33
	<u>3,239.22</u>
Total	<u>\$183,323.47</u>
Grand total	<u>\$271,195.72</u>

Statement of Income and Surplus

General Fund

Year Ended December 31, 1956

Income:

Dues earned	\$79,268.00
Less, Commissions paid.....	297.15
	<u>\$78,970.85</u>
Interest and dividends on investments.....	2,046.07
Rental income	3,275.00
Income from collection of A.M.A. assessments	615.85
	<u>Gross income</u>
	<u>\$84,907.77</u>

Expenses:

Secretary's office	\$29,992.80
Treasurer's office	5,445.39
General	7,708.84
Contingent fund	3,682.87
Public relations	16,390.04
Committee allotments	2,584.79
Building maintenance	8,092.59
	<u>73,897.32</u>
Excess of general income over expenses.....	\$11,010.45
Less, Excess of expenses over income—Journal operations	3,015.12
	<u>Net income</u>
	<u>\$ 7,995.33</u>
Surplus, January 1, 1956.....	\$97,469.27
Less, Appropriations out of surplus:	
Transfer to Building Fund	22,229.31
	<u>75,239.96</u>
Surplus, December 31, 1956.....	<u>\$83,235.29</u>

Details of Expenses

Year Ended December 31, 1956

Secretary's Office:

Personal Services	\$30,274.26
Less, Transferred to:	
Treasurer's office	\$3,250.00
Journal office—extra help	60.00
Committee expense	240.00
Outside addressing	60.00
Collection A.M.A. dues....	750.00
	<u>4,360.00</u>
	<u>\$25,914.26</u>
Executive secretary expense.....	884.91
Executive secretary expense—prior years.....	710.32
Office supplies	270.01
Printing and postage.....	717.25
Automobile expense	491.98
Telephone and telegraph.....	304.63
Bank charges	18.60
Publications	54.30
Social security taxes.....	321.60
Miscellaneous	304.94
	<u>Total</u>
	<u>\$29,992.80</u>

Treasurer's Office:

Clerical and bookkeeping services.....	\$ 3,250.00
Auditors	570.00
Fiscal agent	401.00
Postage and printing—(collection of society dues)	226.48
Collection of A.M.A. dues.....	945.65
Telephone and telegraph.....	37.88
Miscellaneous	14.38
	<u>Total</u>
	<u>\$ 5,445.39</u>

ANNUAL REPORTS

General:

Chairman of council.....	\$ 300.00
President of society.....	300.00
Council	804.74
Delegates to A.M.A. convention.....	2,566.89
Blue Cross premium for employees.....	403.75
Employees pension fund.....	3,333.46
Total	\$ 7,708.84

Contingent Fund:

Seni-annual meeting—House of Delegates.....	\$ 194.73
A.M.A.—1955 Conn. share hospitality.....	1,298.75
Conference of Presidents Dues.....	75.00
Conn. Health League Dues.....	15.00
Public Relation Equipment.....	230.11
Conference on Ageing, New York.....	12.77
Cleft Palate conference.....	54.00
White House Conf.—Traffic Safety.....	46.00
Legal Conf.—Chicago	160.00
Eye Care Committee.....	17.90
Committee on Emergency Medical Service.....	76.89
Barker-Weld Room	335.85
Legal Services—Retirement Plan.....	634.50
Building committee	7.50
Scholarship expenses	4.48
Meeting notices	33.00
Medicare Conference—Chicago	186.02
President's pictures and awards.....	221.75
Miscellaneous	78.62
Total	\$ 3,682.87

Public relations:

Personal services	\$11,482.50
Printing and postage	\$ 1,065.00
Publications and reprints.....	78.27
Clipping service	240.00
Telephone and telegraph.....	209.75
Family health record.....	269.92
Travel and expense—A.M.A. meetings	886.48
Meetings of public relations committee	463.65
Emergency Medical Card.....	422.40
Health Exhibits—County Fairs.....	569.47
Television productions	200.62
Supplies and miscellaneous.....	368.33
Social security taxes.....	133.65
Total	\$4,907.54
Total	\$16,390.04

Committee Allotments:

Public health	\$ 87.11
National legislation	66.08
Industrial health	2.90
Pharmacy joint committee.....	136.76
Medical care of veterans.....	74.16
Council of New England State Medical Societies	126.95
Dental conference committee.....	110.55
Rural health	79.15
Cancer coordinating committee.....	15.00
Committee on foods, drugs, cosmetics.....	89.28

Honorary members	12.00
Maternal mortality and morbidity.....	54.96
Hospital committee	353.57
Professional relations	2.15
Medical education and licensure.....	112.28
Committee on third party payments.....	12.90
A.M.E.F. campaign	868.06
Advisory committee—Welfare Department.....	210.28
Conference committee—Bar Association.....	53.16
Committee on postgraduate education.....	54.00
Cornell crash injury committee.....	33.49
Prenatal morbidity and mortality.....	30.00
Total	\$ 2,584.79

Building:

Taxes	\$ 1,737.02
Custodial services	1,020.00
Insurance	491.93
Electricity, gas and water.....	974.79
Fuel	530.51
Maintenance of grounds.....	410.01
Depreciation and obsolescence.....	1,400.00
Supplies	222.97
Telephone	894.05
Repairs and replacements.....	411.31
Total	\$ 8,092.59

Statement of Journal Operations
Year Ended December 31, 1956

Income:

Advertising (net of commissions).....	\$36,583.61
Subscriptions	1,123.05
Reprints	4,634.40
Electrotypes	321.18
Single copy	8.00
Roster book	77.50
Miscellaneous	32.89
Total	\$42,780.63

Expenses:

Personal services	\$10,327.04
Manufacturing cost:	
Printing	\$29,615.84
Postage and handling.....	1,086.56
Electrotypes	1,254.95
Reprints	2,520.45
Total	34,477.80
Other:	
Printing and postage.....	\$ 89.50
Telephone	43.51
Office expense	172.72
Sales tax	39.70
Clerical assistance	75.00
Travel expense—editor	270.65
Social security taxes.....	172.88
Miscellaneous	126.95
Total	990.91
Excess of expenses over income.....	\$ 3,015.12

**Statement of Income and Surplus
Annual Meeting Fund
Year Ended December 31, 1956**

Income:

Exhibits\$ 8,920.00

Expenses:

Program Committee and Local Com-
mittee on arrangements\$ 5.53
Telephone 39.44
School rental and janitor service..... 452.00
Printing and postage..... 1,568.86
Badges 80.63
Exhibit decorator, rentals and equip-
ment 1,280.00
Meeting operating expenses..... 35.76
A.M. House of delegates..... 421.77
Lunches and dinner expense (guests
and entertainment) 361.67
Extra help, clerical, police, firemen..... 651.26
Speakers and visiting delegates..... 605.85
Council dinner 332.25

5,835.02

Excess of meeting income over meeting expenses..\$ 3,084.98

Surplus, January 1, 1956.....\$17,829.03

Add, Interest earned on savings account 366.85

\$18,195.88

Deduct:

Purchase of automobile.....\$ 1,536.00
Transfer to Building Fund 15,358.82

16,894.82

1,301.06

Surplus, December 31, 1956.....\$ 4,386.04

**Statement of Capital
Special Funds
Year Ended December 31, 1956**

GURDON W. RUSSELL FUND

Balance, January 1, 1956.....\$ 7,432.20

Add, Interest on savings accounts and bonds..... 240.47

\$ 7,672.67

Deduct, Disbursements for sundry items of equip-
ment and furniture..... 805.92

Balance, December 31, 1956.....\$ 6,866.75

O. C. SMITH FUND

Balance, January 1, 1956.....\$ 1,271.16

Add, Interest received on savings accounts..... 33.51

Balance, December 31, 1956.....\$ 1,304.67

BUILDING FUND

Balance, January 1, 1956.....\$ 93,573.88

Add:

Contributions 30,775.00
Proceeds—sale of equipment..... 25.00
Transfer from general fund..... 22,229.31
Transfer from Annual Meeting Fund..... 15,358.82

\$161,962.01

Deduct, Disbursements for sundry items of sup-
plies, printing and postage..... 727.45

Balance, December 31, 1956.....\$161,234.56

BUILDING FUND—RESERVE FOR DEPRECIATION

Balance, January 1, 1956.....\$ 8,997.60

Add:

Interest on savings account..... 280.67
Transfer from General Fund..... 1,400.00

Balance, December 31, 1956.....\$10,678.27

**Statement of Income and Capital
Clinical Congress Fund
Year Ended December 31, 1956**

Income:

Registrations\$ 2,230.00
Exhibits 1,750.00

\$ 3,980.00

Expenses:

Committee meetings\$ 55.36
Speakers 1,040.61
Badges 24.37
Telephone 17.37
Printing and postage..... 883.80
Rentals—Hotel 1,003.45
Projection equipment 150.00
Miscellaneous 105.75

3,280.71

Excess of income over expenses.....\$ 699.29

Surplus, January 1, 1956.....\$ 2,395.77

Add, Interest earned on savings account 70.27

2,466.04

Surplus, December 31, 1956.....\$ 3,165.33

(To be continued)

OBITUARIES

David Russell Lyman, M.D.
1876 - 1956



In the death of David Russell Lyman on October 15, 1956 the Connecticut Medical Society lost a distinguished member.

When in 1903 Dave Lyman first came to Connecticut to take over the management of Gaylord Farm Sanatorium at its very beginning, Connecticut gained a rarely gifted doctor dedicated for his long life to the campaign against tuberculosis. He was to meet his enemy at all levels and to add his wisdom and administrative ability to all activities that might further victory against the enemy.

Gaylord Farm Sanatorium was his greatest life interest and still stands as his greatest memorial. It is less well known that he had much to do with the organization and opening in 1910 of the first State sanatorium and was a member of the State Tuberculosis Commission from 1913 to 1918.

Being among the first to realize that control of tuberculosis was not only a problem of treatment but would require for its accomplishment a vast cooperative effort, he welcomed the organization of the National Tuberculosis Association which embraced doctors, official health agencies, social experts

and the general public and was a founder of the Association at its inception in 1904. In 1918 he became its president and for many years served as director and member of various steering committees.

During the First World War he went to France for the Rockefeller Commission to help organize methods to check the rapid spread of tuberculosis in that country. A few years later he was one of the organizers of the International Union against Tuberculosis. Nearer home he was first president and organizer of both the State and New Haven Tuberculosis Associations.

While control of tuberculosis was his primary objective he was too much of a medical statesman to limit his activity, and throughout his life he supported in every way public health measures, organized medicine and in fact everything pertaining to better medical care. The first dispensary clinic for tuberculosis in the State, located in New Haven, was largely his doing. He organized the Wallingford Visiting Nurse Association and lent his support to visiting nurse organizations throughout the State. He was a member of the State Medical Council for eighteen years and supported and helped organize Employees Relief Associations in several towns and cities in Connecticut. For over fifty years he was a member of Connecticut State Medical Society, its president in 1922. He was also president of the New Haven County Medical Association in 1919, the American Sanatorium Association in 1926, and the American Clinical and Climatological Society in the same year.

Aside from the honor of high office in many professional societies he was not without honors in his own land that bespeak the measure of the man: Yale University gave him an M.A. in 1916 and elected him a Fellow of Branford College; Wesleyan University awarded him its Honorary D.Sc. in 1942. He was commencement orator and honorary Phi Beta Kappa at his alma mater, the University of Virginia, in 1935. The National Tuberculosis Association awarded him its highest honor, The Trudeau Medal, in 1943 and in 1954 he was awarded a gold medal for citizenship by the New Haven Advertising Club. Perhaps he was most pleased by two gifts from his

ex-patients, a stone gateway at Gaylord and a portrait that hangs in the main hall of the Sanatorium, both paid for by spontaneous small contributions as tokens of love and admiration.

I think, however, that he will be remembered not so much because of the many honors and high offices but rather for the unique quality of his personality for he was a man with the rare gift of friendship, the Dave Lyman whom all of his contacts were proud to call friend. His greatest contribution to his generation was the intangible something that he was able to give his patients of hope, courage and returned health.

At the time of the 50th anniversary of the Sanatorium in 1952, Dr. Lyman wrote personal invitations to many of the older group of his ex-patients. Among the replies the letter from Eugene O'Neill probably expresses the feeling of many other patients:

"In the measure that I love my work and am proud to have been able to do the little I have, so much the more deep is my gratitude to you and to Gaylord Farm for saving me for it. My blessings on the Farm spring eternal and it always will be among the most pleasant of my memories."

H. W. Morriss, M.D.

John Law Bridge, M.D.

1859 - 1957

Dr. John Law Bridge, one of Connecticut's oldest physicians, died at his home in Hazardville on January 9, 1957 at the age of ninety-seven. Dr. Bridge was born in Hazardville November 6, 1859, son of the late George and Jennette (Law) Bridge. He attended the Hazardville schools and at the age of fifteen worked for a time in the mills of the now defunct Hazard Powder Co. He entered Wilbraham Academy in 1882, and graduated from Wesleyan University in 1888, a member of Phi Beta Kappa. For two years he served as assistant in chemistry at Wesleyan. He studied further at Clark University and the University of Chicago, receiving a Ph.D. degree from the former. He then taught at Suffield Academy and Waterbury High School. Then entering the Harvard Medical School, he was graduated in 1903. For the next fifteen years he engaged in general practice in Enfield. During that period he was a member and secretary of the Enfield Board of Education.

In 1918 Dr. Bridge moved to Bisbee, Arizona as Medical Examiner for The Phelps Dodge Copper Co. Having spent five years there, he returned to Hazardville where he continued his general practice until his retirement in 1939. He was a member and trustee of the Hazardville Methodist Church and a trustee of the Enfield Cemetery Association. He was a long-time member of the Connecticut State, and Hartford County Medical Associations.

In 1917 Dr. Bridge married Miss Elizabeth Brainard of Thompsonville. She survives him and lives on School Street in Hazardville. Besides his wife, he leaves a sister, Mrs. Elizabeth Abbe, of Springfield, Massachusetts, and several nieces and nephews.

Dr. Bridge was an authority on local history, and will be remembered for his long service to, and interest in, his community. Throughout his life he maintained a lively interest in local, national and world affairs. To the very end of his life he was interested in what was taking place in the world, and in politics. He voted in many national elections, including the November, 1956 presidential election.

Dr. Bridge was buried on January 12 at the New Cemetery in his home community, and will be remembered as an outstanding citizen and friend.

R. Bruce Thayer, Jr., M.D.

William C. Wurtenberg, M.D.

1863 - 1957



Dr. William C. Wurtenberg of New Haven died on March 26 at the age of 94 and there ended one of the most colorful careers in Connecticut medicine.

Dr. Wurtenberg was born in Clarksburg, New York on December 24, 1863, the fifth among fourteen children of George M. Wurtenberg, a miller, and Elizabeth Hochschild Wurtenberg, both German immigrants.

As a boy he attended school only during winter terms and worked on the farm and in his father's mill the rest of the year. In 1879 he entered Griffith Institute, Springville, New York, working his way through two years and then teaching mathematics. In 1882 he organized a select school of his own in Marilla, New York, saved his money and went to Phillips Exeter Academy where he graduated in 1886, came to Yale from which he graduated in 1889 and from the Yale Medical School in 1893.

While an undergraduate at Yale he was editor of the *Banner* and member of Berzelius. After receiving his M.D. degree he did postgraduate work in otolaryngology in Vienna and was among the first to do research in the use of the tuning fork for the measurement of hearing. He wrote extensively on this subject. In 1895 he returned to New Haven, commenced the practice of his specialty and became a member of the New Haven County Medical Association and the State Medical Society.

This could be career enough for one man but any student of Yale football history knows that "Billy" Wurtenberg was one of the football greats. He was in the backfield on Yale's three most famous teams, 1887, nine games played, nine games won; 1888, thirteen played, none lost, running up 698 points to their opponents none, Wurtenberg was the big scorer on this team; 1889, won fifteen, lost one. He was a fabulous fellow in football annals. After returning from Vienna he was the first football coach at Dartmouth College and coached the Naval Academy at Annapolis. Long into later life he was a guest backfield coach to Yale.

Dr. Wurtenberg retired several years ago, maintained his lifelong interest in sports, returned to writing poetry which had been an early avocation and pursued many studies in anthropology. He is survived by his wife and a daughter.

Creighton Barker, M.D.

Clifton Russell Scott, M.D.

1891 - 1957



When word came that recurrent cardiac failure had suddenly taken one of our members it left me with such an empty feeling of loss. A brilliant and unusual man had practised his art and lived out his life. Nothing remained except his contributions to medicine and memories cherished by many of us. Death is so final.

Clifton R. Scott was born November 17, 1891 in Davenport, New York, and died at his home in New Haven on February 7, 1957. He came from a medical family, his father being Dr. Gilbert Scott. A cousin, Dr. James R. Scott, is located in Patterson, New York.

Dr. Scott graduated from Westminster College and subsequently from the Yale University School of Medicine in 1919. After internship and residency at the New Haven Hospital he assumed the newly created post as head of the x-ray department at the New Haven Hospital. In later years he opened his private office at 215 Whitney Avenue, and became consulting radiologist for the New Haven Hospital, the Grace Hospital, and the Griffin Hospital in Derby. He was a member of the New Haven Medical Society and the County, State, and American Medical Associations. He was certified in 1936 by the American Board of Radiology and was also a member of the American Roentgen Ray Society.

However, he was more than an x-ray man. With

constant reading he kept up in many branches of medicine. This, in part, explained his remarkable ability in diagnosing unusual pathological disorders. I never knew him to make an incorrect diagnosis.

He was an enthusiastic hunter and fisherman, belonging to a number of sportsmen organizations. He enjoyed giving his expertly prepared fish to his friends but never ate them himself. He was a Mason and the last rites were conducted by Hiram Lodge, No. 1, A. F. & A. M.

His devoted wife, Mildred Button Scott, was his constant companion. My most sincere thoughts and kindest wishes go out to her now.

Many of us will miss Scotty.

Paul W. Vestal, M.D.

Marion Leonard Robbins, M.D.

1904 - 1957

Marion Leonard Robbins was born October 28, 1904. Her family were New Haven people. She was an active, bright young girl and prepared for college entering Smith and was graduated in 1925. Interested in medicine she first studied at Yale, receiving a Master of Science degree in 1929 and a Doctor of Medicine degree in 1931. During these years she was a bright, attractive, vivacious and brilliant young woman, not only intensely interested in medicine, but gracious socially. She interned at Yale during 1930-31 and then became a house officer at the Lane Hospital in San Francisco during 1931-32. At this time she married Dr. Clarence Robbins also of New Haven and one of the excellent young internists. From 1932-39 she was instructor in pathology and medicine to the Yale School of Nursing and instructor in pathology from 1939-43. In 1935-36 she was assistant professor in clinical medicine and pathology in relation to the Yale School of Nursing. For a number of years she practiced medicine with her husband in New Haven. When World War II broke out and her husband left for the South Pacific with the Yale unit she carried on the work while he was away. She had many grateful patients. Since the end of the war she had been in failing health and was in virtual retirement at the time of her death.

Across the heavens on a starry night
A meteor flashed its shining light
And vanished in horizons gloom.

Frederick W. Roberts, M.D.

Accidental Deaths Keep Rising

The number of fatal accidental injuries in the United States in 1956 is reported by the Metropolitan Life Insurance Company to have shown an increase for the second successive year. The rise in the accident death toll in 1956 is accounted for by the increase in fatalities from motor vehicle accidents. Approximately 40,000 lives were lost in such mishaps, or about 2,000 more than in 1955. Also the number of fatalities per 100 million vehicle miles has increased for the second successive year. Motor vehicle accidents in 1956 accounted for more than two fifths of all accidental deaths in the United States.

The number of lives lost in each of the other main classes of accidents showed no appreciable change from the year before. Injuries sustained in and about the home were responsible for approximately 28,000 deaths in 1956. These fatalities comprised about 30 per cent of the total accident mortality, and thus continued as the second largest category of fatal mishaps. Public accidents other than those involving motor vehicles killed more than 16,000 people during the year. Deaths from injuries arising out of and in the course of employment totaled about 14,000, of which more than 3,000 involved a motor vehicle.

Catastrophes—accidents in which five or more persons are killed—took more than 1,300 lives in the United States during 1956, about 150 less than in 1955. The more favorable record reflects the smaller death toll in major catastrophes—those in which 25 or more lives are lost. During 1956 there were five such catastrophes which accounted for about 270 lives; in 1955 nine catastrophes of this magnitude caused the loss of more than 600 lives.

More than one fourth of the lives lost during 1956 in all catastrophes involving five or more deaths were in motor vehicle accidents. Conflagrations, most of them in the home, accounted for an additional one fifth of the fatalities. Military aviation and civilian aviation each contributed about one seventh of the total. Natural catastrophes, railroad and water transportation accidents comprised the bulk of the remainder.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. E. Roland Hill, Mystic

President-Elect, Mrs. Paul W. Tisher, New Britain

First Vice-President, Mrs. Edwin R. Connors, Bridgeport

Second Vice-President, Mrs. Charles Murray Gratz, Cos Cob

Corresponding Secretary, Mrs. Saul Karpel, New London

Recording Secretary, Mrs. Norman H. Gardner,
East Hampton

Treasurer, Mrs. J. Alfred Wilson, Meriden
President, Mrs. E. Roland Hill

REPORT OF THE PRESIDENT OF THE WOMAN'S AUXILIARY TO THE HOUSE OF DELEGATES OF THE CONNECTICUT STATE MEDICAL SOCIETY

The year 1956-57 marks the thirteenth year of the Woman's Auxiliary to the Connecticut State Medical Society. As we complete this our thirteenth year, we do not consider it an unlucky one, but a fruitful year of progress.

The theme of the National Auxiliary for this year is "Health Is Our Greatest Heritage." We have tried to use this theme in all of our activities. For the benefit of our new members and persons who were not informed, every effort has been made to give the information necessary as to the structure and aims of the Auxiliary and the responsibilities and privileges of being a member.

The Board of Directors of the Auxiliary to the Connecticut State Medical Society composed of seven state officers, chairmen of twenty standing committees, and seven county presidents have held four board meetings. There was also one meeting of the Executive Committee.

The President and the President-Elect, Mrs. Paul Winslow Tisher, attended the National Conference of Presidents and Presidents-Elect in Chicago in October. Your President took part in a panel of AMEF. Also representing Connecticut at this meeting were Mrs. F. Erwin Tracy, National chairman of Public Relations, and Mrs. Dewey Katz, Eastern regional director of *Today's Health*.

The president was also privileged to attend as a guest annual meetings in Rhode Island and Massachusetts and also meetings in all the counties. Some counties were visited twice. The president has also represented the Auxiliary at meetings of various health organizations throughout the State. As Presidential Delegate, the president attended the Annual Convention in Chicago in June and gave a report for the year.

Reports from various committee chairmen are most encouraging and show our organization to be at a high peak of interest and activity.

The Committee on AMEF reports funds in the approximate amount of \$2200 have been raised by the county societies through dinner dances, food sales, and individual contributions. This sum will probably be augmented by \$200 from State funds. The committee chairman, Mrs. Angelo J. Gulino, has received full cooperation from each county in the support of this important program. Appropriate attention has been focused on Medical Education Week.

Through the combined efforts of Dr. John Freiheit and Mrs. Ralph Ogden, Art Committee chairman, the Society's Annual Art Exhibit is being held at East Hartford, where all the various fine art forms as well as ceramic work and photography are being displayed. This year's exhibit has been one of the finest and has indicated a portion of the extensive talent that may be found within our ranks.

Civil Defense, Mrs. Winston C. Hainsworth, chairman, and her committee have been functioning on a stand-by basis.

Our Finance Chairman, Mrs. Alfred B. Sundquist, reports that the voucher system, in use for the second consecutive year, has worked very smoothly, and that our finances are all in excellent condition.

Mrs. T. Smith McLean, historian and necrologist, records the award of a Certificate of Achievement to the Connecticut Auxiliary by the National Auxiliary for outstanding effort in behalf of AMEF. A book has been purchased for use as a permanent record for the names of deceased members.

Mrs. John A. Bucciarelli, chairman of Legislation, has kept us informed on State and National bills currently under consideration. Her committee cooperates at all times with the Medical Society.

At the request of the National Auxiliary the president has appointed a key person in legislation to work with Dr. Meeker, Mrs. R. J. Cook of New Haven. Mrs. Cook is a lawyer, member of the faculty of Yale University, and a past president of our State Auxiliary.

The fine work on the part of the Membership Committee Chairman, Mrs. Edwin R. Connors, assisted by the membership chairman from each of the counties has caused the total paid memberships in the Auxiliary to rise from 1,176 a year ago to 1,220 at the last count.

Mrs. Richard Karpe, Mental Health chairman, has commenced a survey into the juvenile areas of State hospitals to establish the needs which may exist for better or additional services, facilities, personnel, and the like. This is a most ambitious project, and I hardly need state the importance of its being carried through to completion. It is, of course, one of the never ending obligations of the Auxiliary, always to establish those areas where assistance is needed.

As in former years, Christmas found our members wrapping presents and assisting in many ways at our mental hospitals. Every county has participated in this work.

Through the facilities of a large proportion of the State's newspapers, Mrs. William Horton, Publicity chairman, has effected a public awareness of our organization, its activities, and aims. The expounding of the work of the Auxiliary and the major medical issues of the day as explained through the facilities of the Auxiliary is a major function of this committee which has done a commendable job.

Through the efforts of the Editor of the *Quarterly*, Mrs. F. Erwin Tracy, excellent issues have been mailed to all members. We are most appreciative of the CMS contribution which makes this possible.

Much has been done on local levels in Recruitment, under the chairmanship of Mrs. Louis Saxe. Thirteen medical scholarships and six nursing scholarships have been awarded.

Safety has been stressed in programs throughout the year. Mrs. Norman Barker reports that several counties have had a meeting on Safety. At the semi-annual meeting in October, Richard C. Braisted, field representative of Cornell University Medical College, spoke on the studies that his department at Cornell is making on the causes and prevention of highway accidents.

Mrs. Dewey Katz, chairman of the Rural Health and Public Relations Committee, has indicated a most successful year with preparation and showing of health exhibits at fourteen fairs throughout the State. At these exhibits, which proved to be very popular, were distributed several thousand pamphlets and first aid charts. The School Health Committee with Mrs. James Van Leuvan, chairman, along with the Rural Health Committee, has been active in attendance at meetings of the Connecticut Advisory School Health Council which has produced several fine procedures relative to current health problems of public school children. The chairman also attended the meeting of the Connecticut Health League held in New Haven.

The School of Instruction held in September was well attended. This is always an important day. All officers, committee chairmen, and members come to be informed in procedures and methods to be used during the year ahead.

The Auxiliary has taken part in the work of Diabetes Detection. It has also sponsored the training of GEMS (Good Emergency Mother Substitutes) in Girl Scout groups and school clubs.

An active year on the part of the Chairman, Mrs. Royal A. Meyers, has culminated with the Connecticut Auxiliary close to its quota, carrying a total of 1,036½ credits for *Today's Health* as tabulated by mid-March. Extensive canvassing of business establishments, schools, and libraries, as well as members of the medical profession, produced the results as given. Numerous samples of *Today's Health* as well as information pamphlets were distributed in connection with this project.

The annual meeting of the Woman's Auxiliary will be held at the Hartford Golf Club on May first.

During the past year the Auxiliary has paid dues to the

World Medical Association, the Connecticut Health League, as well as the contribution to AMEF.

I am most appreciative of the work of Dr. Creighton Barker, Mr. J. G. Burch, Dr. Winfield Kelley, all officers, committee chairmen, and most especially the county organizations for their help in making this a very happy and successful year.

Mrs. E. Roland Hill

AMA Wives Plan Bang Up N. Y. Session

More than 3,000 physicians' wives are expected to gather at New York's Roosevelt Hotel June 3-7 for the 34th annual convention of the Woman's Auxiliary to the AMA. An interesting program combining business with pleasure, is being arranged by the committee on arrangements, under the direction of Mrs. Harry F. Pohlmann, Middletown, New York, and Mrs. Elliott V. B. Vurgason, Baldwin, New York. National committee meetings and round table discussions will be conducted June 1-3 with the formal opening of the convention slated for Tuesday morning, June 4.

Business sessions on Tuesday and Wednesday will be devoted to state and national committee reports and discussions of current health projects. Tuesday's luncheon, honoring past presidents, will feature an address on "Sick People in a Troubled World" by Dr. Howard Rusk, professor and chairman of the department of physical medicine and rehabilitation, New York University, Bellevue Medical Center.

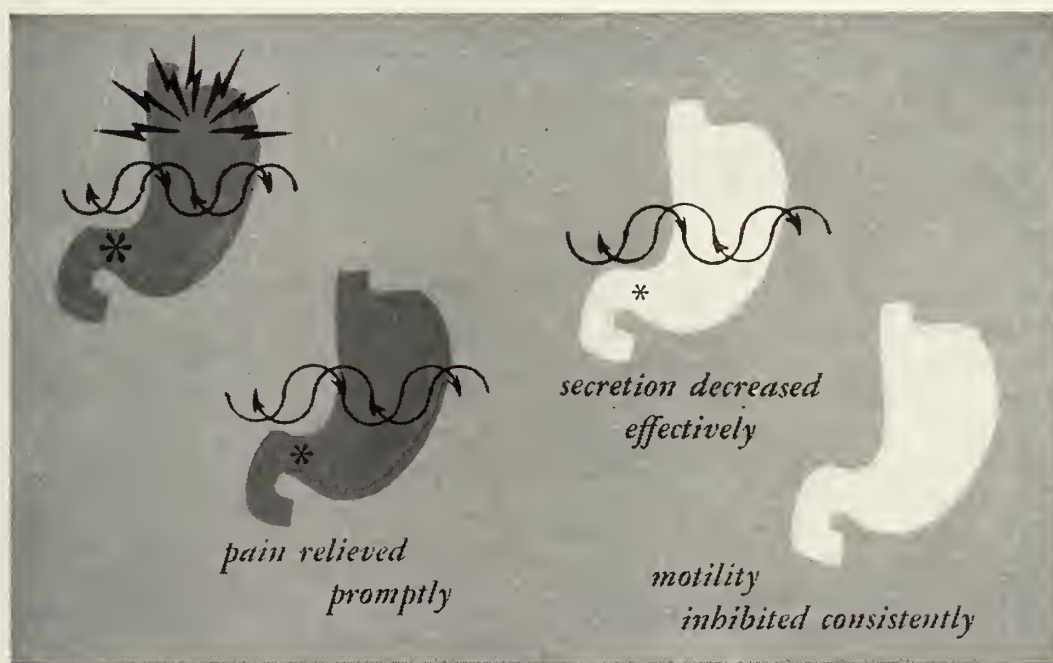
Principal speaker at Wednesday's luncheon in honor of the president (Mrs. Robert Flanders of New Hampshire) and president-elect, (Mrs. Paul C. Craig of Pennsylvania) will be Dr. Dwight H. Murray, immediate past president of the AMA. At this session, Mrs. Flanders will present the Woman's Auxiliary contribution to the American Medical Education Foundation, and Dr. George F. Lull, AMEF vice president, will present AMEF awards to auxiliaries.

Election and installation of national officers will be held on Thursday morning with adjournment scheduled for noon. Climax of the convention activities will be the annual dinner for members, husbands and guests in the grand ballroom of the Roosevelt Hotel Thursday evening. Mr. Allen Richard Foley, professor of history at Dartmouth College, will speak on "Vermont Humor."

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 cases, Am. J. M. Sc. 232:156 (Aug.) 1956.

SEARLE

AROUND THE STATE

Connecticut Advisory Committee on Foods and Drugs Meeting of February 14, 1957

The member societies and institutions were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas N. Fenney; Connecticut State Dental Association, Dr. William Kirschner, Jr.; Connecticut State Medical Society, Dr. Hugh Dwyer; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; Food and Drug Commission, Mr. Herbert Plank; State Department of Health, Dr. James Hart; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Nicholas Giarman.

Representative J. McCullough Turner of Bethany was also present.

THE HAZARDOUS SUBSTANCES BILL

Representative Turner distributed copies of House Bill 162, the Legislative Council version of the hazardous substances bill introduced by Mrs. Prokop; he said that Senate Bill 60 introduced by Senator Minetto was identical with this bill. House Bill 1061, which had also been introduced by Mrs. Prokop "by request," was the bill drawn up in New York on January 8 by representatives of the Manufacturing Chemists' Association and the Chemical Specialties Manufacturers' Association. A fourth bill—House Bill 730, introduced by Representative La Fleur—differed from the Legislative Council bill only in requiring the antidote as well as first aid directions to be carried on the label.

Dr. Fisher remarked that in his opinion House Bill 1061 was with one exception as good a bill as House Bill 162, and perhaps was superior in some respects. The exception was Section 6 of that bill, which was so worded that in effect it required the Commissioner to run laboratory tests to prove that a product was poisonous before he could take any action against it. (Section 6 of HB1061 stated that "If the commissioner shall find that any substance is a poison as defined in Section 1(f) of this act, he may . . . require such package or container to be labeled in accordance with the provisions of this act;" since the definitions in the "Section 1(f)" referred to were solely in terms of pharmacological tests on animals, in effect this language meant that

the Commissioner would have to conduct such pharmacological tests before he could proceed against a manufactured product.)

On motion of DeVita, seconded by Giarman, it was voted that the Committee back House Bill 162 (the Legislative Council bill), modified by substituting "the antidote" for "instructions as to first aid treatment" in Section 3(f), at the hearing on February 21.

THE POISON CONTROL CENTER BILL

Dr. Fisher, who had been appointed by State Health Commissioner Osborn on October 26 as chairman of a committee to study the advisability of establishing a poison control center (or centers) in Connecticut, reported that his committee had met on January 9 and agreed to back a bill drawn up by Robert Keehn of the State Department of Health after certain modifications were made. In essence this bill (which was later introduced by Senator Squillo as SB194) appropriated \$38,000 for two years to establish a poison information center within the State Department of Health, which would maintain a file on the composition of hazardous substances and be on call 24 hours a day to supply information from this file to physicians who needed to know the composition of market products their patients had swallowed. The committee believed that the Hartford Hospital was the most desirable location for this center because medical personnel of the hospital emergency room would be readily available for consultation if needed.

THE CHANGE IN NAME AND COMPOSITION OF THE COMMITTEE

Prof. Fenney reported that in accord with the action taken at the December 6 meeting he had written each of the sponsoring agencies requesting its ratification of our vote for: (1), the change of name; and (2) the addition of representatives of the Food and Drug Commission, the Pharmacy Commission and the State Department of Health as non-voting members. Approval had been received in all cases. He announced that as a result of these replies we were now officially "The Connecticut Advisory Committee on Foods and Drugs."

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FOR SALE—Our special for the month—Continental shock-proof fluoroscope, excellent condition, \$395.00—Complete milex stainless, gynecological set, \$60.00 value for \$25.00—Two hour General Electric time clock, \$7.00—Brown-Buerger examining and operating cystoscope, \$125.00—Burton examining lamp \$17.00—Gooseneck lamps, \$8.00 up—Bircher hand ultra-violet cold quartz lamp with Woods filter \$50.00—Stryker electric cast cutter \$65.00—National Twin Transilluminator, complete \$25.00—National cautery, pistol grip handle, \$30.00—New tycoos sphygmomanometer \$34.00—Mercurial pressures \$18.00—Microscopes \$85.00 up—Welch-Allen and Bausch and Lomb otoscope sets \$22.00 up—Medcolator muscle stimulator, \$125.00—Sterilizers, \$30.00 up—Infra-red lamps, \$25.00—Hanovia ultra-violet lamps \$50.00—Bargains in ophthalmic equipment, nose and throat instruments, tremendous savings on stainless instruments, etc. Hundreds of items to choose from. We guarantee everything we sell. Write or phone BEverly 7-3145 for information. Harry Sacker, 188 Grove Street, Meriden, Connecticut.

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Prof. Fenney added that Food and Drug Commissioner Frassinelli had appointed Herbert Plank as his representative, and the Pharmacy Commission had appointed Dr. Felix Blanc as its representative, with Chief Inspector Edmund Goodmaster as alternate. No notice of appointment had yet been received from State Health Commissioner Osborn.

WIPE OFF THAT BEARD

Dr. Fisher reported that his laboratory had finally completed its analysis of the "Vitene" ingredient of the preparation devised by Joseph Bard of Hartford for preventing the growth of hair on the face (the other ingredient was hydrogen peroxide). The composition of "Vitene" (whose manufacturer had designated it for an entirely different noncosmetic use—removing ink from rollers in printing plants) was found to be as follows:

	GM./100 CC.
Triethanolamine oleate	13.09
Free triethanolamine	19.02
Sodium sulphate (Na_2SO_4)	1.88
Tin, lead and iron.....	traces

That is, "Vitene" was an aqueous triethanolamine soap solution containing excess free triethanolamine.

Dr. Fisher stated that because two entirely separate cases of extreme sensitivity to triethanolamine soaps had been encountered by his own laboratory within one year's time he had a strong suspicion that sensitivity to triethanolamine was more widespread than was generally admitted; for this reason he did not believe "Wipe Off That Beard!" to be safe for general use.

SUGGESTED AMENDMENTS TO THE LAW WITH REGARD TO VETERINARY PRACTICE AND THE SALE OF VETERINARY DRUGS

Dr. DeVita said that the following four bills had been introduced into the General Assembly by the Connecticut Veterinary Medical Association:

HB1168 was designed to prevent the sale of veterinary drugs to unqualified persons; it provided that those drugs which may not now be purchased for human use except by prescription of a licensed practitioner could not be purchased for animal use without the prescription of a veterinarian.

HB1170 was designed to control the use of hormones in animals to be used for food by man; it required all substances of a hormone character (whether natural or synthetic) which were intended for implantation or injection for slow absorption to

be colored so that their presence could be easily detected and the area containing them could be excised and discarded.

HB1174 required ointments, liquids, etc., intended for intramammary injection, or introduction in any manner into the mammary gland or udder of an animal producing milk for human consumption, to be colored with a dye that would color the milk from the diseased gland.

HB1448 was intended to revise the Veterinary Practice Act so as to correct certain practices not in the best interest of the public health and safety.

Reporting Blindness

The State Board of Education of the Blind is obligated by statute to maintain a register of blind persons in Connecticut. Through the years, physicians and optometrists throughout the State have provided whole hearted cooperation in reporting their blind patients. This has given us knowledge of many persons who should be added to the register and be informed of the numerous and substantial services and benefits which are available.

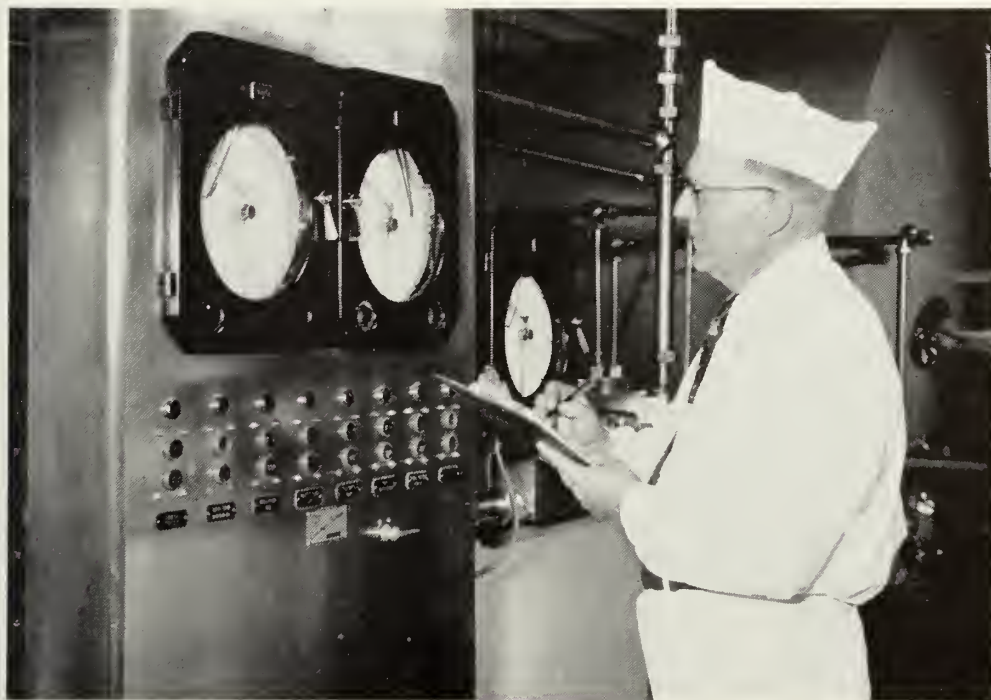
Effective July 1, 1955 such reporting was made compulsory by legislative action. The statute reads as follows:

"Section 1005d. Reports of blind persons by physicians and optometrists. Each physician and optometrist shall report in writing to the board of education of the blind within thirty days each blind person coming under his private or institutional care within this State. As used in this section, the term 'blind person' means any person whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity is greater than 20/200 but is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees. The report of such blind persons shall include the name, address and degree of vision. Such reports shall not be open to public inspection."

This new law has been helpful, not so much from the viewpoint of compulsion, but on the basis that doctors have become more generally aware of the importance of reporting blind persons.

Based on the formula of 1.52 blind persons per thousand inhabitants of Connecticut in an estimated population of 2,233,000, the number of blind persons

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in the State is 3,497. Until we have the name of each one of these in our register, this Board has not completed its full obligation according to statute or in meeting the possible service needs of blind individuals. This is a matter of continuing concern and effort for us. We urge the complete reporting cooperation of doctors as a major source of our referrals.

In March 1957, the following letter was sent to eye doctors throughout the State:

"We have been asked by doctors, 'What happens after we send a compulsory report form on blindness to your office?'"

"We think that you will be pleased with our procedure, which is designed to offer services without intrusion.

"First, we mail a form letter, a copy of which is enclosed herewith, to the newly reported client. If the enclosed postal reply card is not returned, we then telephone to the home to inquire whether a visit is desired. We do this to protect the privacy and follow the desires of the reported client, who will receive a professional visit only if he requests it. Of course, most clients want a call as soon as possible in order to arrange for a Talking Book Machine, regular visits from a Home Teacher, real estate tax exemption, or other service.

"Your cooperation in prompt reporting will be helpful to your new blind patients."

The brief form letter which is sent to newly reported clients reads as follows:

"As your State agency, we provide much information and many benefits for Connecticut residents with visual handicaps. Enclosed is a descriptive leaflet. Our representative would like to meet you soon to discuss your interest and to arrange for any of our services which may be advantageous to you.

"If for any reason you prefer that she not visit, please reply by the enclosed card. Otherwise she will notify you in advance, making a definite appointment for her call."

Copies of a report form on blindness are available from the Board and will be mailed on request. One copy has been sent already to each eye doctor in the State. In addition to keeping a comprehensive register, this Board desires to work with doctors in providing service for their blind clients. Suggestions for increasingly effective service and cooperation are always welcome.

Connecticut Blood Program

One of the little publicized yet important phases of the Connecticut Blood Program is the production of fresh frozen plasma for the treatment of hemophilia.

Approximately 2,400 units are processed annually in this Center, this being a larger amount than any other Red Cross Center in this country. This amount also is the maximum which can be produced, since all blood must be taken from blood-mobile operations near the Center in Hartford. Specific types are frequently requested at mobile unit operations since the distribution by type of hemophiliacs is not that of the distribution by type of the population as a whole.

Approximately 30 pints of blood, freshly processed into plasma, are used by each hemophiliac family in Connecticut.

	JULY 1, 1956 THROUGH MARCH 31,	
	MARCH 1957	1957
DONORS		
Donors accepted	8,617	65,780
Donors rejected	777	6,914
Donors registered	9,394	72,694
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from Center	6,494	55,333
Blood collected by hospitals.....	979	6,524
To fractionation stock pile.....	144	673
To out of state hospitals.....	154	886
	7,771	63,416
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	92	879
Processed into packed cells.....	11	64
Processed into liquid plasma.....	551	7,254
	654	8,197
Discarded—unfit and broken.....	59	506
Grand Total—distribution of blood....	8,484	72,119
Blood returned to Center for processing into plasma and fractions.....	544	6,430
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	56	475
Fresh frozen plasma (125 cc.).....	140	1,642
Serum albumin (100 cc.).....	129	1,544
Packed red cells (bottles).....	11	64
Fibrinogen (bottles)	0	8

Medical Staff Chiefs at NEHA

Medical staff chiefs from six New England hospitals conferred on staff discipline as a feature of

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COTTAGE CHEESE

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the second day's session of the three-day meeting of the New England Hospital Assembly on March 25, 26, 27, at the Hotel Statler, Boston. The discussion was presided over by O. J. Bizzozero, M.D., chief-of-staff, Waterbury Hospital, and was introduced by I. S. Geetter, M.D., director, Mount Sinai Hospital, Hartford.

The panelists discussed "What are the Duties and Responsibilities of a Chief-of-Staff Relative to the Total Hospital Organization?" During the discussion the panelists told what a medical staff chief considers to be the proper relationship between the medical staff, the administrator, and the governing board.

Alcohol Commission's Program Under Study

Raymond G. McCarthy of Yale University's Center of Alcohol Studies has been named director of a study to determine the effectiveness of Connecticut's alcoholism clinics in reaching and treating the State's estimated 90,000 alcoholics. Mr. McCarthy is an associate professor of health education at Yale and associate director of the University's School of Alcohol Studies.

Dr. Dudley P. Miller, executive director of the Connecticut Commission on Alcoholism, also announces that to assist Mr. McCarthy two New York University research consultants have been engaged who will participate in the study.

They are Dr. Gerhart Saenger, social psychologist who is director of the Graduate School of Public Administration and Social Service at NYU, and Dr. Donald Gerard of NYU's Research Center for Human Relations.

Governor Ribicoff's Finance Advisory Committee has approved the expenditure of \$7,600 from the Commission's Special Fund Account to finance the design, organization and pretest phase of the evaluation project which must be completed by June 30, 1957. The complete study will require an additional two years with budgetary requests for its support now before the General Assembly.

Appointment of the researchers opened the first phase of the project which Mr. McCarthy says will seek to measure both the effectiveness of the Commission's treatment services for alcoholics and their families and the success of its educational facilities in furthering understanding and prevention of alcoholism. Connecticut was the first State to pro-

vide systematic and professional health care for the alcoholic when it opened its Hartford clinic in 1946.

In evaluating the Commission's treatment of patients, Dr. Miller says the study will examine its effects on their drinking and behavior patterns, their family and job status, records of arrests and public support and earnings.

Educational services will be measured by direct contact with selected and representative samples of public and private agencies and of individuals to determine changes in their understanding of alcoholism, attitudes toward the alcoholic, and awareness and use of treatment resources since the establishment of the Commission.

Connecticut Hearing Aid Society

These hearing aid consultants were elected officers at the recent annual meeting of the Society held in Waterbury: President, Joseph Newbury, Torrington; First Vice President, Roy Henion, Waterbury; Second Vice President, Allen Dubin, Bridgeport; Third Vice President, Mrs. A. W. Hackett, New Haven; and Secretary-Treasurer, Preston Zimmerman, Hartford.

The Connecticut Hearing Aid Society, formed in 1956, is an outgrowth of the former Hartford Hearing Guild. Membership in the Society is limited to Connecticut hearing aid consultants who devote their abilities and knowledge to the fitting, dispensing and servicing of aids to hearing, and who maintain rigid standards of conduct. The purposes of the Society are to promote and maintain a professional level of conduct and ethics and to encourage cooperation among consultants with members of the medical professions and with institutions and persons working in audiology and rehabilitation of individuals who have impaired hearing.

Fairfield County

John H. Heller, director of the New England Institute for Medical Research in Ridgefield, has been named to the president's advisory committee of the Instrument Society of America. Dr. Heller, who has long been an outspoken proponent of the urgent need for better instrumentation for measurement and analysis on a molecular level, was named as an expert on medical and biological instrumentation. He is the designer of several instruments including a spectrofluorimeter and electrophoretic apparatus for medical research.

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Norwalk Hospital has initiated a special scholarship program designed to offer to outstanding graduate medical students from leading European medical centers an opportunity to spend a year in the United States learning American concepts of modern medicine. The Board of Trustees has selected Dr. E. T. Bradley of New Canaan to visit a number of medical centers in Europe to arrange for the selection of these candidates who will spend a year at Norwalk Hospital.

William H. Curley of Bridgeport has been reelected to the Board of Directors of Connecticut Blue Cross. He is the only physician serving on that body. Dr. Curley is chief of the Department of Surgery at St. Vincent's Hospital, Bridgeport and chairman of the Committee on Third Party Payment of the State Medical Society.

D. OLAN MEEKER TO AMA COMMITTEE

D. Olan Meeker of Riverside is one of four new members recently appointed to the Committee on Legislation by the AMA Board of Trustees. Dr. Meeker will be the member of this committee responsible for the six New England States. Each State will have a key man whose duty it will be to effect the formation of a legislative committee in his State, if one does not exist, and to urge the appointment of a legislative representative in each county.

All this is in the interest of improving the AMA's legislative program.

Candidates for membership in the Fairfield County Medical Association and their sponsors were invited to attend an indoctrination dinner meeting at the Stratfield Hotel on April 3. Present at that time were officers of the Association, members of the Board of Trustees, Board of Censors, Committee on Medical Ethics and Department and Public Relations Committee. Among the speakers were Creighton Barker, executive secretary of the Connecticut State Medical Society. Twenty six candidates were elected to membership at the Annual meeting held April 9.

R. Harold Lockhart, Bridgeport, was elected president of the Fairfield County Medical Association at its 165th Annual meeting held at the Stratfield Hotel, April 9 in Bridgeport. He succeeds J. Donald Corridon, South Norwalk. Elected to the post of vice president was G. Gray Carter, Greenwich. Michael A. Dean, Bridgeport, was reelected secretary and Thomas J. Tarasovic, also of Bridge-

port, treasurer. The latter succeeds Joseph C. Quatrano, who did not seek reelection.

Elected to the Board of Trustees for four year terms were William T. Clark, Bridgeport and William M. Stahl, Jr., Danbury. Leaving the Board of Trustees were Morris P. Pitock, Bridgeport and John Murray, Greenwich, having served four year terms.

Elected chairman of the Board of Trustees at its organization meeting was Louis Rogol, Danbury, who has one more year to serve.

The Public Relations Committee, elected for the first time at the annual meeting of the Fairfield County Medical Association on April 9, consists of nine members. The Committee members and their term of office are as follows: For three years, M. David Deren and Milton M. Lieberthal, Bridgeport and William A. Sinton, Danbury; for two years, Frederick J. Christie, Greenwich, George R. Cody, South Norwalk, and Allen M. Margold, Norwalk; for one year, D. Olan Meeker, Riverside, Louis Rogol, Danbury, and Charles Sheard, Stamford.

The Fairfield County Medical Golf Association is expected to play its first and qualifying round at the Mill River Country Club, Stratford, May 22. President of the body is Thomas J. Tarasovic, Bridgeport. Other officers are Edwin R. Connors, Bridgeport, secretary; Edwin F. Trautman, Trumbull, treasurer; Joseph P. Connolly, Stamford, president-elect.

Hartford County

William F. Reardon, former president of the West Hartford town council and former chairman of its zoning commission, died on March 29 at the Veterans Hospital in Rocky Hill at the age of 70.

Stewart P. Seigle of Hartford together with the executive secretary of the Hartford County Medical Association, Mr. Joseph L. Gordon, served as co-chairman of the awards promotion committee of the eighth annual Northern Connecticut Science Fair. The Fair was sponsored by the *Hartford Times* and was held in the West Hartford Armory the first week in April.

Ralph M. Tovell, chairman of the department of anesthesiology at the Hartford Hospital, was one of the panel members in a symposium on "The Anesthesiology Resident Program" conducted recently by the Illinois Society of Anesthesiologists.



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HARTFORD'S NEW HOSPITAL CHAPLAIN

Rev. E. Wendell Stephan, the first hospital chaplain for Protestants in Hartford hospitals, began his duties on April 8. The chaplaincy was established by Lewis Fox in memory of Miss Anna M. Fulling. Rev. Stephan comes to Hartford from a chaplaincy at the Creedmore State Hospital in Queens Village, N. Y. A special recognition service was held in his honor at the Asylum Hill Congregational Church on April 9 under the auspices of the Greater Hartford Council of Churches.

Litchfield County

Andrew Orłowski, physician at the Torrington plant of the American Brass Company, was named a Fellow of the Industrial Medical Association at its annual meeting in St. Louis in April. This honor was accorded Dr. Orłowski in recognition of his activities in the field of industrial medicine.

Middlesex County

Mario Palmieri, who was the Health Director of Middletown before 1945, and who several times since then has been Acting Health Director, on a part time basis, will on May 1 become the full time Health Director of Middletown.

D. Leonard Lieberman was in Chicago the latter part of March to attend the annual meeting of the American College of Allergists.

On April 15 Gordon LaVelle joined Clair B. Crampton *et al.* in the practice of obstetrics and gynecology at 52 Crescent Street, Middletown.

Another man to enter private practice is Anselm Schurgast. He has just resigned from the staff of the Connecticut State Hospital. His practice will be limited to psychiatry and his office will be at 66 South Main Street in Middletown.

F. Erwin Tracy attended the annual meeting of the American College of Physicians in Boston early in April.

New Haven County

Michael S. Shea of New Haven, a member of the JOURNAL Editorial Board, has been admitted into the Knights of St. Gregory. Members of this order are named by the Pope in recognition of their outstanding work for humanity and religion.

The officers of the New Haven County Medical Association for the coming year are Charles T.

Flynn, New Haven, president; George Fox, Meriden, vice president; Cole B. Gibson, Meriden, secretary-treasurer. Jacques H. Green, Waterbury, retiring president, was elected to membership on the executive committee. Dennis S. O'Connor, New Haven, was presented with an award of the President's Committee for the Employment of the Physically Handicapped.

Yale University School of Medicine

Clarence D. Davis, professor of obstetrics and gynecology at University of Missouri Medical School, has received an appointment as assistant professor of obstetrics and gynecology at Yale. In addition to his teaching of graduate and postgraduate courses he will be a key investigator in the interdepartmental research project on cerebral palsy. The project, supported by a grant of \$425,199 from the U. S. Public Health Service, is conducted by the Yale Department of Obstetrics and Gynecology, Pediatrics, and the Section of Neurology.

Lawrence S. Kubie, professor of psychiatry at Yale, delivered the Porter lectures at the University of Kansas School of Medicine on the subjects "Neurotic and Creative Processes," "Scientific Creativity and the Learning Process," and "Art and Literature."

The December, 1956 issue of *The Yale Journal of Biology & Medicine* is dedicated to the late John Punnett Peters, John Slade Ely professor of medicine at Yale. Several essays on metabolism appeared in this number, written by former students and colleagues of Dr. Peters.

AMA Survey on Doctor's Help

The doctor's secretary can save him a tremendous amount of time by performing many of the semi-technical and most of the business activities in the office—if she's well trained and possesses certain important personal qualities.

That is what a nationwide survey, in which the AMA cooperated, revealed recently. Harold Mickelson of the Division of Business Education, Northeast Missouri State Teachers College, completed the study.

To find out the ideal knowledges, skills, and personal qualities of medical secretaries, Mickelson sent

(Continued on page 486)

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BRIDGEPORT

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Union Monopoly Power

The National Association of Manufacturers has just released a 31 page booklet entitled: "Monopoly Power As Exercised by Labor Unions." It is an interesting and highly informative publication which discusses the broad issue of union monopolistic powers and practices.

The booklet is the result of a year's study by a group of experts on labor-management problems. The group sought to determine, on the evidence of actual histories, the extent to which labor unions in the U. S. hold and exercise monopoly power. The last chapter in the book, which will be distributed to members of Congress and State legislatures, offers some proposed solutions to the problem.

One pertinent paragraph in the final chapter says: "It has been our objective to bring about public understanding. . . . This report is concerned only with the public interest and with the preservation of the human rights and freedoms to which all are entitled in our democracy. It does not seek to benefit one group at the expense of another, but to make clear a situation which is harmful to all groups, including the unions themselves."

CALIFORNIA CAREER OPPORTUNITIES FOR PHYSICIANS AND PSYCHIATRISTS. Employment available as a result of interview only. Assignments in State hospitals, juvenile and adult correctional facilities, or a veterans home. Three salary groups: \$10,860-12,000; \$11,400-12,600; \$12,600-13,800. Salary increases being considered effective July 1957. Citizenship, possession of, or eligibility for California license required. Write Medical Recruitment Unit, Box A, State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

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AMA SURVEY

(Continued from page 484)

mail questionnaires to over 500 top-notch women selected by medical societies, and he interviewed a number of educators and physicians personally. A summary of his findings, entitled "The Medical Secretary: Her Duties, Training, and Role on the Medical Team" has just been published by the AMA's public relations department and is now being sent to state and county medical societies, business educators, and medical assistants' groups.

Mickelson analyzed the activities performed in physicians' offices, classifying them into three categories: (1) highly technical medical activities which, under normal conditions, only a physician can perform; (2) semitechnical medical activities which may be performed satisfactorily by medical office personnel under the supervision of the physician; and (3) business office activities of a routine or management nature which are ideally performed by the secretary or aide.

Semitechnical activities are those related to the examination or treatment of patients, including such duties as preparing and draping patients, weighing, taking temperatures and blood pressures, assisting with minor office surgery or treatment procedures, giving certain types of injections, sterilizing instru-

ments, and conducting some laboratory tests, such as urinalysis and simple blood tests.

His survey points out that "physicians are not making maximum use of their extensive training when they unnecessarily perform semitechnical medical and business activities." To help doctors determine what responsibilities can be delegated properly to office personnel, Mickelson is currently preparing a system for assigning duties which will be furnished to medical societies by the AMA within the next few months.

Suggestions for course content in medical secretarial training programs, contained in the survey, will be particularly valuable to business schools and junior colleges training medical office employees, and to medical societies working with such schools to expand existing courses or develop new ones. Survey findings will also be of interest to societies sponsoring short courses for doctors' aides and to medical assistants' organizations interested in "post-graduate education" for members.

The study which also tabulates physicians' opinions about necessary personal qualities in the ideal medical secretary, will provide a pattern for screening candidates for medical office jobs. In the future the AMA hopes to prepare an evaluation guide based on the survey for physicians to aid in hiring properly qualified secretaries.

SPECIAL NOTICES

**MIDDLESEX MEMORIAL HOSPITAL
MIDDLETOWN, CONNECTICUT**

**Medical Education Program for the Month of
May 1957**

Wednesday, May 1, 10:00 A. M.

Tumor conference

Friday, May 3, noon

Grand rounds

Monday, May 6, noon

Clinical-pathologic-conference

Friday, May 10, noon

Grand rounds

Monday, May 13, noon

Norman L. Cressy, M.D., assistant superintendent, Uncas-Thames Sanatorium

Current concepts of medical treatment of pulmonary tuberculosis

Friday, May 17, noon

Grand rounds

Monday, May 20, noon

Phillip K. Bondy, M.D., associate professor of medicine, Yale University School of Medicine

Should urinase be used in the treatment of diabetes?

Friday, May 24, noon

Grand rounds

Monday, May 27, noon

Ira Goldenberg, M.D., instructor, Department of Surgery, Yale University School of Medicine

Post obstructive small bowel dyskinesia—a new syndrome

Wednesday, May 29, noon

Gilbert H. Glaser, M.D., chief, Section of Neurology, Yale University School of Medicine

Infections of the nervous system

Friday, May 31, noon

Grand rounds



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bottle of 7-Up**

Why look at the *back* of a 7-Up bottle?

Here's why. On the back of the bottle are listed all the ingredients of this sparkling, crystal-clear drink.

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Nothing does it like Seven-Up!
The Seven-Up Bottlers of Connecticut

MEDICAL-LEGAL SYMPOSIUM

Place: Hartford Club, Prospect Street, Hartford.
Time: 4:30 P. M., May 6, 1957.

Occasion: Medical-Legal Symposium jointly sponsored by the Connecticut State Medical Society, the Connecticut State Bar Association, the Hartford County Medical Association, and the Hartford County Bar Association.

4:30-5:15 P. M. Discussion of Interprofessional Code between Medicine and Bar Associations

Hon. James F. Kennedy
Thomas M. Feeney, M.D.

5:15-6:00 P. M. Medicine and Law

Superior Court Judge Raymond J. Devlin

6:00-7:00 P. M. Cocktail hour

7:00-8:00 P. M. Dinner, Ballroom Hartford Club

8:00 P. M. Tax problems of common interest to physicians and attorneys.

Henry Shepherd, Esq.
Hon. J. Ronald Regnier

New England Conference of State Nutrition Committees
Hotel Bond, Hartford
May 20-21, 1957

The Connecticut Nutrition Council as host is celebrating its tenth anniversary.

Registration fee \$7 to include dinner Monday evening and luncheon Tuesday.

American Psychiatric Association
Chicago, Illinois
May 13-17, 1957

Congress of International Association of Audiology
St. Louis, Missouri
May 14-16, 1957

International Congress for the Study of the Bronchi
Lisbon, Portugal
May 25-26, 1957

Thirst, too, seeks quality



American College of Chest Physicians
New York City
May 29 - June 2, 1957

39th Annual Meeting of Endocrine Society
New York City
May 30 - June 1, 1957

Society for Applied Anthropology
East Lansing, Michigan
May 31 - June 2, 1957

National Industry Safety Conference of the Royal Society
for the Prevention of Accidents
Scarborough, Yorks, England
May 31 - June 2, 1957

American Diabetes Association
New York City
June 1-2, 1957

Society for Investigative Dermatology
New York City
June 1-22, 1957

Congress on Metabolic Disorders of Gynecological and
Obstetrical Origin
Rome, Italy
May 29 - June 4, 1957

International Congress of Public Health Physicians and
Surgeons
Turin, Italy
June 1-9, 1957

American Medical Association
New York City
June 3-7, 1957

Tenth International Hospital Congress
Lisbon, Portugal
June 3-7, 1957

International Symposium on Blood Circulation
London, England
June 4-9, 1957

Fifth International Congress on Therapeutics
Utrecht, Netherlands
June 5-7, 1957

SPECIAL NOTICES

Canadian Medical Association
Edmonton, Alberta
June 17-21, 1957

Faculty of Radiology—Annual Meeting
London, England
June 21-22, 1957

9th International Congress of Rheumatic Diseases
Toronto, Canada
June 23-28, 1957

4th International Orthopedic Congress
Rome, Italy
June 27-29, 1957

12th International Congress of Industrial Medicine
Helsinki, Finland
July 1-6, 1957

Eleventh Annual Rocky Mountain Cancer Conference
Denver, Colorado
July 10-11, 1957

Sponsored by the Colorado State Medical Society and the
Colorado Division of the American Cancer Society

World Medical Association
Istanbul, Turkey
September 29-October 5, 1957

AMERICAN ASSOCIATION OF REHABILITA- TION THERAPISTS, ASSOCIATION FOR PHYSI- CAL AND MENTAL REHABILITATION, ASSOCI- ATION OF MEDICAL DIRECTORS AND COORDINATORS

The Convention of the joint organization above will be
held at the Conrad Hilton Hotel in Chicago on July 7 to
12, 1957.

ANNUAL ASSEMBLY IN OTOLARYNGOLOGY

The Department of Otolaryngology, University of Il-
linois College of Medicine, announces its Annual Assembly
in Otolaryngology from September 30 through October 6,
1957. The Assembly will consist of an intensive series of
lectures and panels concerning advancements in otolaryng-
ology, and evening sessions devoted to surgical anatomy of
the head and neck and histopathology of the ear, nose and
throat.

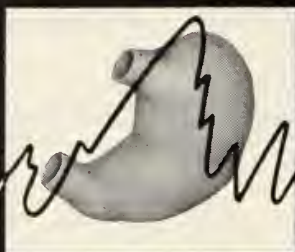
Interested physicians should write direct to the Depart-
ment of Otolaryngology, 155 West Polk Street, Chicago
12, Illinois.

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SEARLE

NEW BOOKS IN REVIEW

THE CARE OF THE EXPECTANT MOTHER. By Josephine Barnes, M.A., D.M. (Oxon), M.R.C.P. (London), F.R.C.S. (England), F.R.C.O.G., Assistant Obstetrician and Gynaecologist, Charing Cross Hospital and Elizabeth Garrett Anderson Hospital; Surgeon, Marie Curie Hospital. New York: Philosophical Library, 1956. 270 pp. \$7.50.

Reviewed by STANLEY B. WEID

With meticulous attention to detail the author of this book discusses the subject of antenatal care. She rightly emphasizes the importance of thorough examination of the expectant mother, including attention to the blood grouping, chest x-ray, and x-ray pelvimetry in addition to the urinalysis, hemaglobin and blood tests for syphilis. She is more sanguine about the value of cephalometry than are many obstetricians in this country. Her discussions of home

deliveries and of the maternity services in Britain will be of only academic interest to the American obstetrician.

Several chapters are allotted to abnormalities such as multiple pregnancy, hydramnios, and malpresentations. Emphasis is placed on discovery of these early. The various types of pelves are considered and their relationship to disproportion. Thirty-five years is established by the author as the age limit beyond which all primigravida should have a Cesarean section in the presence of any degree of pelvic contraction. Many will not agree with her statement that "surgical induction of labour introduces an element of interference, which carries with it a risk of uterine sepsis." However, an entire chapter is devoted to induction of labor.

The last portion of the book deals with diseases complicating pregnancy. This is very complete.

This volume represents lectures and antenatal ward rounds in which the author instructed medical students and pupil midwives. The author's many hospital appointments and scientific society memberships testify to her professional standing in Britain. The book is well illustrated, of legible type, and printed on a good grade of coated paper.

THE PROBLEMS OF AGING

EDWARD L. BORTZ, M.D., *Philadelphia, Pennsylvania*

AGING AS A MEDICAL CHALLENGE

The medical needs of older individuals are an entirely different problem, medical speaking, than those of young adults and children. The characteristics of disease entities in the elderly are frequently modified by tissue changes and alterations in function. There is the aspect of diminished reserve. There is the phase of sluggish response to therapeutic agents. There are many factors that affect the older individual apart from those of other age groups. Therefore, with the new therapeutic agents available today it becomes necessary for the physician to make every effort to have a broad understanding of his patient.

Numerous surveys concerning long term illness have been made during the past five years. The Commission on Chronic Illness has conducted studies in various communities. Findings indicate that while these illnesses may afflict individuals of any age, those over sixty constitute the highest percentage. This becomes a grave medical challenge because illness afflicts an individual at a time when he is least capable of meeting it physically, emotionally and financially. The threat to his security is a drain and may foster emotional disturbances which will add insult to injury.

The families of the elderly are frequently distressed because they are shifted from one physician to another if they perchance get into the hands of specialists. In no field of medicine is the need more pressing today for the old fashioned type of family physician with the newest methods of diagnosis and treatment than is the case with the elderly individual. If geriatrics is to become a specialty as pediatrics developed in the middle of the nineteenth

The Author. *Associate Professor of Medicine, Jefferson Medical College, and University of Pennsylvania Graduate School of Medicine*

SUMMARY

There are certain phenomena of far reaching importance taking place in the current era. Medical science is on the march. The better it succeeds, the longer people will live. The longer the vitality of individuals extends, the greater the impact on our social fabric.

Statistics indicate that, in the past decade, there has been a geometrical increase in the number of individuals over sixty-five. In fact, it has been estimated that every day over one thousand citizens are reaching the sixty-five birthday. This, in itself, is a sign of what is coming. The average age of retirement, established by industry, at the opening of the twentieth century was sixty-five years. This is an outmoded custom that needs revision.

century, then the best man to become the geriatrician is the general practitioner or, as you like to call him, the generalist.

GERIATRICS AS A SPECIALTY

I have a minor enthusiasm for the development of special fields of practice. It seems unnecessary to have a physician limit his practice entirely to the needs of elderly individuals. That is not the solution, as I see it. However, there is an immediate demand for physicians to take a much broader interest, and be more sensitive to the many effects of illness in the elderly. In the first place, there are many more

Presented at the Annual Scientific Assembly, Connecticut Chapter, American Academy of General Practice and Lederle Laboratories, Hotel Statler, Hartford, Connecticut, October 25, 1956

history of our nation. In the second place, there is a great deal more known about the peculiarities of these elderly folks and what should be done about them. In the third place, we have a keener understanding of the nutritional needs of the elderly. Then we also have at our finger tips the potent medicines in the form of sulfa drugs, antibiotics, vitamins, the hormones, the tranquilizing agents, and other specifics for the protection of the health of older individuals. Unless the busy practitioner clearly understands these various potent preparations and indications for their use he is not going to be able to meet the demands required of him.

There are several excellent magazines available now that carry interesting articles on the various aspects of the needs for the elderly. These journals report the important researches going on in the biological, physiological, clinical and sociological fields and also some papers deal with the psychology of aging individuals. A field of medical literature is now being built up that is reviewing recent developments of significance touching on the lives of our older patients.

There are meetings being held now by state and national groups carrying programs concerning the needs of the elderly. Also, the American Medical Association has just recently formed a Committee on Problems of Aging.

TRENDS IN MORTALITY

If one examines the vital statistic tables of the past five years compared with those at the turn of the century one finds that the degenerative diseases constitute the major threats to long life. The disorders of the vascular system, heart disease, hardening of the arteries, hypertension, coronary occlusion, stroke and thrombosis, destroy approximately eight hundred thousand lives each year. Second in occurrence is cancer and this disease killed some two hundred and twenty-four thousand in 1955. Then there are the other diseases, accidents, and injuries; tuberculosis has gone down in the list recently. Then there is nephritis, diabetes and pneumonia. In these groups we find the major illnesses of patients in the higher years of life.

A great deal can be done for these individuals and important researches are being continued in these various fields. As more individuals are living into the higher years of life they are living long enough to become candidates for these wear and tear disorders. Added to these specific diseases there

is the accumulation of the residual of various insults and traumas to the tissues of the body in the early years of life. These unfavorable conditions existing in the body in the aggregate set the stage for a consuming long term illness to shorten the life of the individual.

PHYSIOLOGICAL CHANGES WITH AGING

Certain changes take place in the body with the passage of time. Man ages. What takes place depends upon the quality of the tissues, that is, the hereditary endowment of the individual plus the many experiences that occur as the individual grows. The life span may be divided into conception, growth, development, maturation, involution. The various infectious disorders, accidents, stresses, and strains, faulty nutrition, and the numerable alterations in speed of function all have an influence on the balance of the cells' activity. Just what makes up the undiluted experience of the cell in pure aging aside from the deleterious external influences that are brought to bear upon this cell has not been clearly identified. The early experiences of an individual from the time of birth through infancy, childhood, and early adult periods are fairly fixed epochs in the life span of the individual. The vigor of the middle and the higher years of life depends to a great deal on the experiences that the cells of the body have as they move along.

Biological homeostasis appears to be fairly stable throughout the entire adult life span. For example: first, the acid base equilibrium of the blood remains remarkably constant and shows no unusual excursions in the higher years of life. Second, the blood sugar level may increase slightly in the higher years although it remains likewise within the normal for homeostatic balance. Third, absorption of vitamin A is constant throughout life. Fourth, the eosinophil response to corticotropin does not change. Fifth, the ability to retain the nitrogen when given an increased amount of protein by mouth. This is a valuable observation as pointed out by Shock.¹

It has been recorded that aging cells show a diminished amount of protein. This is a constant finding in cells that have not received adequate nourishment. This may be a very significant observation.

Aging seems to be a gradual running down process of the basic power of the individual. There is a progression of unfavorable changes occurring in tissues which may in the majority of cases ulti-

of these individuals than at any previous time in the maturely become irreversible. But these alterations have not been universally observed. With the unfavorable progressive changes in the tissues there is a loss of functional reserve.

It has been stated that the main characteristics of aging, in man, are atrophy of tissues. Here the deleterious changes occur at various times and at different rates and in different organs. As the oxygen supply to the tissues decreases, the number and size of the cells also decrease. If there is an increase in the supply of oxygen to the cells produced by moderate exercise, this deleterious effect may be diminished or delayed. Ultimately, with insufficient activity of the cells, they shrink in size and with the inadequate quantity of oxygen, there is a gradual and partial replacement of specialized cells of the various organs by less differentiated tissue. That is to say, in the liver, in the heart, in the brain, and other organs, like the bone marrow, there is an increase in the connective tissue.

A deposit of pigment, lipochromes, in the cells with calcium occurring in the cartilages has been noted. As the tissues age they become more dry and dense. As the density of the tissue increases there are organic and inorganic inclusions and the tissue colloids become more concentrated. As the tissues become dry the nitrogen content decreases.²

It is important to grasp the significance of these changes. No adequate checks have been made to determine whether or not any or all of these deteriorations might be influenced by diet, exercise, and more balanced living. It has been thought for some time that the aging of tissues is accelerated by any prolonged increase in stress which has been permitted to go to the stage of exhaustion.

C. S. Davidson³ believes that elderly persons tend to lose interest in eating and they eat food high in starches and sugar and low in proteins. There is then a deficiency in the protein supply to the body and obviously there would be less protein found in the cells. This may be a definite factor in accelerating the aging process.

In his classic essay on old age, "The Major Involution," Warthin divides the primary tissue changes of involution in four parts. First, numerical atrophy of cells. Second, quantitative atrophy. Third, shrinking and condensation of intracellular substance. Fourth, vascular changes with collapse of blood vessels and calcification.

SECONDARY PATHOLOGICAL CONDITIONS ASSOCIATED WITH AGING

Warthin has listed a number of tissue alterations that are common in the body of an aging person. Individuals show loss of memory and loss of self control with eccentric behavior. There are numerous clinical evidences of senile decay of the nervous system. The eye shows an arc of senilis with cataract and loss of visual acuity. Changes in hearing and changes in thyroid function have been recorded. In the heart and the blood vessels there is loss of elasticity and smoothness of the lining of the blood vessels with resulting disorders of heart function, coronary occlusion, generalized hardening of the arteries. In the lung are there is a shrinkage of the tissues with loss of air functioning vesicles due to lack of use. Other tissues of the body, the kidneys, the liver, the prostate, the pancreas, and the tissues in the bones all show definite deterioration in the structure of the cells. With this deterioration loss of satisfactory function is inevitable.

DEFECTIVE TISSUE REPAIR

Tissue culture today is being carried on in many experimental laboratories. It is known that cells and various tissues may be kept in a state of good physiological balance for many, many months. Connective tissue cells and many other cells may be maintained in a state of active mitotic growth for years as shown originally by Alexis Carrel.

Inability of tissues to repair themselves satisfactory in aging bodies has been a point of conjecture in the minds of many thoughtful investigators. They have an impression that collections of waste elements and other products in the plasma and the liquid elements of the body maintain a sufficient concentration of deleterious materials that tissue replacement and self renewal cannot take place as effectively and completely in older bodies as in younger bodies. Here again the influence of diet, exhaustion, exercise and various other influences have not been adequately evaluated. This is an area which promises much important information when the experiments can be carried to completion.

It would be well to again point out that individuals are living longer than in any former period. Some beneficial influences are taking place within the body so that the cells are able to continue some twenty-five years longer now than was the case a short half century ago. Changes for the protection of important key organs in the body are in process.

Just how far the degeneration of cells may go and yet be able to be reversed is not yet proven. We do know, for example, in the pancreas a state of exhaustion may produce temporary diabetes. This is possible by taking an experimental animal, loading its blood with sugar so that the secretory function of the cells which manufacture insulin is completely exhausted and the pancreas can no longer carry on. This may likewise be produced by the use of certain chemicals, such as alloxan. When the deleterious ingredient has been eliminated the cells renew themselves and return to normal. Here is the key to long life. It resides within the cells of the body, and the ability of cells and tissues to renew themselves under optimum conditions. This is the secret of length of life. The better the state of nutrition, the maintenance of homeostasis of the blood stream, and tissue fluids with avoidance of overloading and exhaustion, the longer will the cells and the longer will the individual live.

HANDICAPS TO NUTRITION IN OLDER PERSONS

There are certain important handicaps to adequate nourishment of the cells of older bodies.

1. There is a slowing of physiological processes. This may be moderately speeded up by exercise.
2. There is a sluggishness of the circulation. Here again is a state of affairs which may be improved by certain tonics such as the vitamins and some of the elixirs, plus increase in body activity.
3. Impaired liver function. This is common but by no means a constant finding. It is a result usually of faulty diet habits over a long period of time, plus the excess use of fatty foods, plus inactivity of the body.
4. Diminished basal body metabolic rate. As individuals grow older and reduce their physical activity their basal metabolic rate tends to drop.
5. Absence of teeth. However, with a noticeable improvement in oral hygiene there is a better state of affair in the mouth of older individuals and this is not, by any means, as common now as it has been in the past.
6. Diminished or absence of gastric acidity. As individuals grow older there has appeared to be a dampening down of the secretion of the gastric acidity. However, although this occurs in approximately two thirds of individuals over seventy five years of age, with general hygienic improvement of body function this likewise may be stimulated.

7. There is ordinarily diminished pepsin, trypsin, and lipase. Some experiments indicate that if the individual is stimulated his digestive processes may respond satisfactorily.

8. Insufficient fluids. It has been generally reported that old cells are dried and shrunken cells. Individuals tend to take insufficient fluids as they grow older.

9. Reduced secretion of urine. This is, of course, a result of lack of adequate intake of fluids.

10. Constipation. This state of sluggish function probably not only of the bowels but poor hygiene of the kidneys, the skin, and the lungs may result in retention of waste products in the body.

11. Insufficient absorption of vitamin D.

12. Inadequate absorption of calcium.

As individuals grow older the aging skeleton tends to spend the calcium and the bones become brittle. This is a common report in older books in pathology. We have no definite proof that these changes are irreversible, at least in the early stages in the life of the cells. The impression of the aging cells that has been received at the autopsy table is a rather depressing one in that it shows the inevitability of the progressive deterioration of cells. No adequate experimental work has yet been reported of the reversibility of these findings. It would seem that experimental observation of the various tissues, under varying conditions of physiological activity with variation of food intake, would yield important information that should be of value in establishing the rhythms of cell function as the individual ages.

THE ENLARGING LIFE CYCLE

Science is gaining better insight into the causes and effects of the various diseases on the human body. It is also obtaining a better appreciation of the circumstances and with improved public health and personal hygiene the human life span is being increased. The life cycle is enlarging. With this increase in life there is opportunity for new diseases to appear. Such is the case. Recently there has been a stimulating article in the *New England Journal of Medicine* entitled: "Diseases of Medical Progress." In this paper the author lists the number of newly appearing disorders which have been the result of modern methods of treatment. It seems that the medical profession brings one disease under control and in so doing produces two or three new entities.

SIGNIFICANT RESEARCHES

For some time we have been interested in producing vascular degeneration in the blood vessels of experimental animals. We have found that in a group of rats on a restricted caloric intake with diets adequate in the basic foods which the body requires and under exercise the experimental animal may be kept in a state of health sufficient that his sleekness of coat, brightness of eye and fertility index may be maintained thirty per cent longer than rats kept at average conditions on an average diet. Studies are now in progress with other strains of animals.

Individuals who have been carrying on an active work life have been compared with those whose work was of a sedentary type. Persons who follow a sedentary activity, who eat generously but not wisely, tend to show a more advanced deterioration of the blood vessels than do those who are on a more modest caloric intake and who at the same time have been active physically. These observations have been made by Morris and his colleagues and reported in the *Lancet* some two years ago.

Lansing⁴ has pointed out that some authorities have likened aging to the running down of a clock, the wearing out of an automobile part or a pair of shoes. He states also that the difficulty with these concepts is that the living cell is not a clock nor a mechanical device since these latter are nonliving systems. They do not possess a self renewal mechanism. The living cell does. A critical diagnostic feature of living tissue is the capacity for self renewal. This capacity can be measured in turn by studies with radioactive isotopes. The various constituents within the cells are being constantly replaced at varying times. If in the aging tissues there are old protoplasmic constituents present, it can only be due to inadequacy of the self renewal mechanism. Lansing theorizes that aging may be primarily due to an insufficient rate of protoplasmic self duplication. Now the important observation here is that with an improvement of the cells to carry on this self renewing ability they will function longer. If they have all of the specific nutrients that are required for self renewal, if cellular exhaustion and tissue depletion can be avoided, cells will not deteriorate so rapidly. Improvement of oxygen supply to the tissues from exercise, the ability of cells to self renew their tissues is the protection for a longer period of life. Here is the key to long life and optimum function of the biological cell. This

is the base from which all further studies should proceed.

Lansing points out again that, in senescence, there is a progressive accumulation of toxic materials within the cells. These materials, whether they are pigments, crystals, compounds, or products of incomplete metabolism, are supposed to interfere with optimum cell function. It has been stated that in senescence the permeability of the cell membrane has been changed by an increase in the calcium content of the cell surface. However, there is no substantial evidence to prove that this is correct. Here again, if optimum conditions for survival are encouraged such as exercise and healthy activity, one would presume that the life cycle of the individual cell could be increased.

Aging has been described as the result of reduced growth potential. It is a reduction of the ability of the cell to self renew itself. This is reasonable and can be tentatively accepted. Unfortunately there is a scarcity of top flight investigators interested in this fascinating area of biology. Those in this field are Lansing, Shock, Warren Andrews and Cowdry. They have made observations of the greatest significance.

Aging is difficult to define. There are benefits that come with the passage of time in certain aspects of human existence. For example, the acquiring of knowledge, the ability and opportunity to broaden emotional experience and deepen its values, the opportunity of intellectual growth and participation in the intellectual affairs of the world, the chance for enjoying social experiences and the participation and support of wholesome social activities which contribute to the common good, and finally, with the passage of time, with the aging of an individual there are increased opportunities for an evaluation of life itself. It gives a person a chance through enjoying the various fascinating phases of human living to find himself in the family of man. But to come back, there are unfavorable changes in the tissues of the body correlated with the passage of time which appear at varying stages. The time of appearance is the key again to the speed of the onset and progression of unfavorable changes leading to the inevitable death of an individual.

Thirty years ago, in an important monograph entitled "The Biography of Death," Raymond Pearl summarized his conclusion: the problem of natural death has two aspects. One, general, the other, special.

1. Why do living things die? What is the meaning of death in the general philosophy of biology?

2. Why do living things die when they do? What factors determine the length of time, in general, and in particular? What is the relative influence in each of these? These two questions are the same we are faced with today.

Pearl lists five biological generalizations about natural death.

1. There is an enormous variation in the duration of life.

2. There is no relationship between the average duration of life of individuals composing a species, and any other broad fact as metabolic rate, duration of fetal life, and longevity.

3. Natural death, as distinguished from accidental death, is preceded by definite structural and functional changes in the body. However, we believe that these structural and functional changes may be so altered by improving the environment within which the cell functions, that is, maintenance of the chemical balance within the body, maintenance of optimum exercise, and general hygiene, so that there is a minimum opportunity for exhaustion and for the accumulation of deleterious waste products to exist in the cellular environment.

4. Natural death occurs normally and necessarily only in animals composed by many cells.

5. Life itself is a continuum. Natural death is something new which has appeared in the long course of human evolution over a period of millions of years. The death of higher organisms such as man is the price that must be paid for the privilege of enjoying higher specialization of structure and function. These have been added as a side line to the main business of living things which is to pass on in unbroken continuity the never dimmed fire of life itself.

Here we are face to face with some of the most fundamental and awe-inspiring problems of the biology of aging. We also are faced with the opportunity of bringing new light into this fascinating area. It may be that when a few of these basic problems are solved, regarding the continuity of life within the cells of the various organs of the body, there may be an amazing increase in the human life

span. This is not only within the realm of possibility, it is now beginning to look very probable. In the light of these new and significant findings, renewed enthusiasm should be a motivating, driving force for our highly qualified investigators who are searching for light in the dark recesses in human biology, and the various psychological processes. There are now to be solved the problems of just why cells which make up the blood vessels of the heart, the brain, the kidneys, and elsewhere in the body deteriorate? It looks as though the incomplete products of metabolism, such as the intermediary lipoproteins and other substances, act unfavorably when they exist in too high a concentration within the blood vessels. There is, also, something which occurs within the cells to cause them to lose their sense of belonging to a particular system of growth that ends in a special organ and with the deviation from normal growth, there is the first beginning of cancer growth. And, here within the cell man must find the original state of affairs that produces an out-law among the cells and may result in the death of the individual.

When one considers the basic biological alterations occurring in arthritis, rheumatism, and nervous and mental disorders, one must again come back to some alteration of the structure and function of the cells which make up these organs. It becomes a study of the environment, the atmosphere in which the cells live. Here one must deal with the nutrition of the cells, the accumulation of waste products, with the installation of toxic products such as excessive concentrations of alcohol, tobacco, nicotine, drugs of various kinds, plus the stresses and strains that produce a deleterious and unfavorable state of affairs within the cells. One cannot avoid dealing with fundamentals here. Then, when these conditions are brought under control, human existence may, as stated before, enjoy another spectacular increase in the life span.

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LIVER DISEASE IN PREGNANCY

HENRY M. WILLIAMS, M.D., *West Hartford*

LIVER FUNCTION IN NORMAL PREGNANCY

Although there have been many studies demonstrating alterations of hepatic function during the course of gestation, there is no general agreement as to the frequency and degree of these changes; accordingly, a rather general summary of these findings follows:

Some authors¹ have found the thymol turbidity and cephalin flocculation tests unaltered in normal pregnancy, but others^{2,3,4} have noted abnormal thymol in 15 per cent of cases and abnormal cephalin flocculation in 5 to 40 per cent of normal pregnancies. Serum bilirubin may be normal¹ or elevated in 8 to 20 per cent of cases,² and slight delay in excretion of injected bilirubin is reported in normal pregnancy.⁵ Various authors¹⁻⁴ have found the excretion of bromsulphthalein in 45 minutes to be delayed in 17 to 50 per cent of cases (per cent retention ranging from 6 to 10 per cent). Other work has been cited³⁰ suggesting that alkaline phosphatase is frequently elevated in the normal pregnant state.

Over half of normal pregnant women have hypoalbuminemia and more than one third have hyperglobulinemia.^{4,6,10} It has been suggested that the hyperglobulinemia may be due to increased rate of synthesis on the basis of isotope turnover studies, but it is not clear as yet whether the hypoalbuminemia is due to diminished rate of synthesis or increased rate of degradation. A depressed rate of hepatic synthesis of cholesterol has been found experimentally⁷ although this may be related to the high blood estrogen levels in pregnancy since a similar effect can be produced by administration of estrogens. Likewise decreased cholesterol esters (average 46 per cent esterification) were noted in 23.3 per cent of normal pregnancies.⁴ A fall in plasma cholinesterase activity in the second and third trimesters of normal pregnancy has been noted⁸ but since these changes parallel alterations in blood volume, it has been suggested that they may represent hemodilution.

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The Author. *Former Resident in Medicine,
Hartford Hospital, Hartford, Connecticut*

SUMMARY

The results of liver function tests in normal pregnancy have produced no definite conclusions. Likewise, there have been no striking differences found in such tests between normal and toxemic pregnancies. Infectious hepatitis occurring in pregnancy gives a poor prognosis, not only for the mother but also for the infant. Interruption of pregnancy is advocated in the presence of hepatitis in the first trimester. Rupture of the liver in pregnancy usually occurs in the presence of pre-eclampsia or eclampsia. Acute fatty metamorphosis of the liver in pregnancy is a rare disease resembling viral hepatitis. Equally rare is cirrhosis of the liver in pregnancy.

The literature relevant to liver disease and pregnancy is reviewed, and from a consideration of the latter it is apparent that although such complications are uncommon, the associated mortality is high. Therefore these patients require meticulous, joint medical-obstetrical management based on an adequate understanding of the interplay between liver disease and pregnancy.

Liver blood flow has been found to be normal in pregnancy⁹ as has the prothrombin time.⁴ The work of Ingerslev and Teilum is cited² as finding no histologic changes in liver biopsy specimens obtained during normal pregnancy.

THE LIVER IN PRE-ECLAMPSIA AND ECLAMPSIA

Formerly acute yellow atrophy occurring during the latter part of gestation was considered to be a specific manifestation of toxemia. Although in recent years it has become clear that most of these cases represented instances of viral hepatitis occurring in the last trimester, it is still accepted that some specific hepatocellular abnormalities may accompany severe eclampsia; Lichtman⁴ cites the

work of Ingerslev and Teilum as well as studies done by Nixon who found that although there were no histologic changes in the livers of pre-eclamptic patients, about 50 per cent of eclamptics showed characteristic lesions consisting of hemorrhagic necrosis in the peripheral portion of the hepatic lobules and fibrinous thrombosis of branches of the portal vein. These changes which may be sufficiently widespread to give diffuse necrosis of the liver,⁴⁴ have been found in 50 per cent of women dying of eclampsia and at times may be very striking.¹² However, in all likelihood the pathology represents a terminal event rather than the cause of eclamptic symptoms.

In general the differences between normal and toxemic pregnancies with respect to laboratory measurement of liver function have not been striking: BSP retention¹ and plasma cholinesterase are the same in both. Although Dieckmann³ found no difference in cephalin flocculation and thymol turbidity in one series, another group studied by him² showed more frequent abnormalities in thymol and cephalin flocculation in toxemic pregnancies; there was some suggestion that elevation of the cephalin flocculation early in pregnancy might predict the occurrence of pre-eclampsia in the third trimester; this problem, however, has not been satisfactorily resolved. Electrophoretic studies¹¹ show a greater degree of hypoalbuminemia and hyperglobulinemia in pre-eclampsia and eclampsia than in normal pregnancy. Likewise, patients with toxemia have shown increased retention of injected bilirubin compared with that found in normal pregnancy.⁵

INFECTIOUS HEPATITIS

As already mentioned, the majority of patients exhibiting diffuse hepatic necrosis in association with pregnancy represent instances of viral hepatitis occurring during gestation. Although this combination is not common, the reported incidence varying from 0.022 per cent^{16,17} to 0.048 per cent¹⁴ of pregnancies, it is generally agreed that the co-existence of viral hepatitis and pregnancy augurs for a mutually poor prognosis. In a review of the available literature¹³⁻³⁰ a total of 126 cases of hepatitis associated with pregnancy have been collected; 22 of these mothers died, giving an overall mortality rate of 17.5 per cent which is considerably in excess of the accepted mortality for sporadic hepatitis in nonpregnant individuals of 0.2 per cents.⁴⁰ Undoubtedly the literature is heavily weighted with

fatal cases, but even so an increased mortality of hepatitis in pregnancy seems certain. Furthermore, the great majority of fatal cases tend to occur in the third trimester, at which time the mortality has ranged from 40 to 100 per cent.³

As far as the late effects on the mother are concerned, sporadic cases of chronic hepatitis are reported; combining the results of two studies on the late effects of hepatitis in pregnancy on the mothers,^{23,27} of 23 available cases, 13 had one or more abnormalities in liver function studies done six months to fourteen years after the acute episode. This incidence exceeds that usually accepted for late sequelae of infectious hepatitis. (About 0.6 per cent of cases may ordinarily be expected to show clinical or laboratory evidence of hepatic abnormality after one year⁴⁰).

An increased infant mortality and incidence of prematurity are also consequences of this combination. Of 56 births collected from the literature from mothers who had hepatitis during pregnancy^{13,14,15,16,17,20,24,25,26,27,28,29} there were 41 survivals, an infant mortality of 27 per cent. However, effects have been noted even in those living; although some studies reveal no abnormalities in these children,²⁷ there are reports of severe congenital anomalies occurring in infants whose mothers had infectious hepatitis during the first trimester;²⁶ in addition, Mansell²⁹ collected 21 cases of infectious hepatitis occurring during the first trimester: three of these ended in spontaneous abortion and 5 additional cases showed congenital abnormalities. These reports would certainly seem to indicate that transplacental transmission of the virus occurs, although this has been denied.¹⁹ However, Stokes is quoted²⁵ as having transmitted the virus of serum jaundice from the mother and from one of the infants in his series to volunteers. Further evidence of transplacental transmission of the virus is afforded by reports of neonatal hepatitis^{24,25} or cirrhosis²⁸ occurring in infants born of mothers who had infectious hepatitis. The prognosis of neonatal hepatitis is grave and about 50 per cent of these infants succumb.^{31,32}

As far as the management of this complication of pregnancy is concerned, prophylactic gamma globulin should be given to prospective mothers exposed to the virus of infectious hepatitis. The recommended dosage varies from 0.01 to 0.1 cc. per pound of body weight;^{36,37,38} Ashley has reported a reduction in the attack rate in household contacts

from 15.2 per cent in the control group of 0.6 per cent in those in whom immune globulin was given in doses of 0.01 cc. per pound of body weight.³⁹ The agent may be effective even when given as late as six days before the expected onset of the disease (incubation period ranges from 10 to 50 days).

When hepatitis does occur in pregnancy the usual management is indicated including bed rest until the bilirubin is below 2.0 mg. per cent and cholesterol esters have risen to normal and are stable. However, the alterations in liver function occurring during normal pregnancy must be kept in mind in the laboratory evaluation of the course. High carbohydrate diet is probably advisable and if prothrombin levels fall, supplemental vitamin K should be given and preparations made to manage postpartum hemorrhage. In the face of an unfavorable clinical course, both steroids and intravenous aureomycin have been used with benefit. The role of glutamic acid therapy in the management of overwhelming liver necrosis is not clear at present, but this agent may be helpful in hepatic coma.

The problem of interruption of pregnancy is not so simple, although the reported incidence of congenital abnormalities suggests that therapeutic abortion should be recommended when hepatitis occurs in the first trimester. When the disease occurs in the second trimester, a conservative attitude is generally recommended as far as interruption of pregnancy is concerned. However, there is no general agreement as to what course should be followed in the third trimester. Some authors^{14,17} feel that pregnancy adversely affects the course of infectious hepatitis and that interruption of pregnancy by conservative means should be accomplished once the child has reached 36 weeks gestation. Others²¹ do not feel that termination is necessary and indeed some^{20,30} suggest that early termination of pregnancy may even make matters worse, as the disease may be more serious in the postpartum period, with the fatalities in the third trimester partially related to the onset of premature labor.

The conservative course would seem to be to treat the patient vigorously for hepatitis and continue the pregnancy unless the clinical course becomes unfavorable, at which time termination of pregnancy might be advocated if feasible.

RUPTURE OF THE LIVER

Spontaneous subcapsular hematoma of the liver³³ and rupture³⁴ during pregnancy are rare occur-

rences, only 14 cases having been reported in the literature, with a mortality of 64 per cent.³⁵ Since almost all cases have occurred in association with pre-eclampsia or eclampsia, it has been suggested that the hemorrhage and subsequent rupture begin in small areas of hepatic necrosis which are secondary to the toxemic state. Right upper quadrant pain and tenderness accompanied by signs of shock have been prominent clinical features. Early operation and repair of the rupture have resulted in recovery.³⁵

ACUTE FATTY METAMORPHOSIS OF THE LIVER

This interesting lesion was first described in detail by Whitacre and Fang⁴¹ and has been recently reviewed in some detail.⁴² Only 14 cases have been reported in the literature with one recovery, a mortality rate of 92.9 per cent.

Clinically the picture resembles viral hepatitis occurring in pregnancy: late in the third trimester there is onset of jaundice which is clearly of the hepatocellular variety; liver failure supervenes, the patients become progressively worse even after delivery and die in hepatic coma. The pathologic picture is distinct from viral hepatitis: there is diffuse fatty metamorphosis of the liver with preservation of the lobular architecture. The peripheral portion of the lobule is usually not involved and there is no necrosis except possibly minimal paracentral changes, with little if no inflammatory cell infiltration. There may or may not be fatty metamorphosis of the renal tubular epithelium.

There are two theories as to the etiology of the observed changes: 1. That it may represent acute nutritional failure in the pregnant liver which already has a slender reserve and is more susceptible to dietary failure. 2. Or it may be due to the action of some humoral agent (hormone or toxin) which is present because the patient is pregnant or exerts an abnormally destructive effect in the pregnant state. There is no good evidence to support either of these contentions at present.

The diagnosis can be established with certainty only by liver biopsy. When recognized, a vigorous hepatic therapeutic program should be begun and if the patient does not respond promptly to therapy, the pregnancy should probably be interrupted.

CIRRHOSIS OF THE LIVER AND PREGNANCY

Only 15 cases of cirrhosis of the liver in association with pregnancy have been reported,^{6,41} so that this combination is extremely rare. Undoubtedly this

is because cirrhosis occurs more frequently after the childbearing age, for various sociological reasons, and also the liver disease may well have an adverse effect upon the fertility of the patient. Four of the reported cases have died, a mortality rate of 26 per cent, although there have been no deaths in the last five cases reported and these authors feel that when the cirrhosis is not advanced, pregnancy and labor can be safely conducted. Usually no special therapy except for a high protein diet has been employed.

DISCUSSION

It is apparent that although minor alterations in liver function occur with regularity in pregnancy, the complication of hepatic disease is uncommon, but represents a serious problem. Undoubtedly eclampsia may be associated frequently with hepatic necrosis, sometimes sufficiently diffuse to be fatal, or occasionally preceding spontaneous hematoma or rupture of the liver. Jaundice in late pregnancy may also represent acute fatty metamorphosis or viral hepatitis; only liver biopsy will distinguish the two. The mortality of viral hepatitis in the third trimester is high, so that this complication requires meticulous medical and obstetrical management. Indeed, upon reviewing the 14 maternal deaths that have occurred at the Hartford Hospital in the past decade, two were noted to be the result of this complication; in other words, 14 per cent of maternal deaths in the past ten years have been secondary to viral hepatitis occurring in the third trimester of pregnancy.

The high incidence of fetal anomalies associated with viral hepatitis in the first trimester also poses a serious problem that warrants further study, for therapeutic abortion may well be the wisest course; the occasional occurrence of neonatal hepatitis and cirrhosis strengthens this view. The frequent persistence of hepatic abnormalities in mothers who have had hepatitis during pregnancy is also disturbing. Undoubtedly this too reflects an increased susceptibility of the liver during gestation, and should be a further indication for careful and conservative management of this complication.

In spite of the number of studies that have been done there still seems to be confusion as to what changes in hepatic function are to be expected during the course of normal pregnancy. That this uncertainty makes the diagnosis of hepatitis more difficult was illustrated by a recent case in which elevation of alkaline phosphatase was interpreted as a normal accompaniment of pregnancy, while in

reality this represented early changes produced by viral hepatitis secondary to infectious mononucleosis occurring in the third trimester. Since such confusion could lead to unfortunate delays in treatment, it is suggested that careful reappraisal of alterations in liver function occurring during pregnancy might represent a useful contribution, and would certainly facilitate the diagnosis and management of liver disease occurring in association with pregnancy.

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COLIC

Its Causes and Successful Treatment in Otherwise Healthy Infants

ARTHUR S. BRACKETT, M.D., *Riverside*

MOST textbooks, when discussing the subject of enteric colic, offer no effective treatment for relief from its symptoms but stress the well recognized fact that time, unassisted, will eventually achieve a cure; and therefore patience is prescribed. However, even with patience, continual crying often wears thin that loving welcome with which a baby has been received into a family, and more rarely leads to temperamental unbalance of a parent. To cite an extreme: only recently the New York papers carried the story of a father accused of killing his own child who pleaded that the continual crying had driven him crazy.

Fifty years of active practice, including twenty five years' experience conducting a "Well-Baby" clinic, has convinced me that many cases of colic can be effectively treated when due regard is given the mechanical and motor functions of the digestive tract, which are too frequently overlooked by the medical profession. Cases such as those described below which I have encountered in my private practice, in the "Well-Baby" clinic and in the wards of the Bristol, Connecticut, Hospital demonstrate that colic can be successfully treated and that a great deal of suffering can be replaced by the joy which the infant and his family should have in their new relationship.

Colic has long been recognized, and discussed in the medical literature; and the treatment which I have found effective is not altogether new, although there seems to have been general lack of recognition of the principal cause of colic, which is as simple as the overflowing of a teakettle when put on to boil—trying to put into it more than it can properly hold.

Simon Andre Tissot, a well known French writer of the eighteenth century, published in 1760 a book on "Advice to the People," translated into every European language. This book included a chapter on "cholic" and its different kinds (page 306 of the third edition).

The Author. *Consulting Pediatrician, Bristol Hospital, Bristol, Connecticut*

SUMMARY

After fifty years of active practice the author presents a common sense and simple method of treating colic in infants. The regimen consists essentially of furnishing frequent feedings of small volume. With premature infants concentrated feedings as often as every hour are recommended without moving the baby. Case reports are furnished to substantiate the thesis.

William Buchan discussed colic in his "Domestic Medicine" published in 1770.

Deweese, professor of midwifery at the University of Pennsylvania in the early nineteenth century, said of infant colic that "Old women call it the 'three month bellyache'." He noted that the crying was usually worst from 4 to 6 P. M. His treatise on the "Physical and Medical Treatment of Children" published in 1825 went through ten editions.

John Eberle (1788-1838), professor of the theory and practice of medicine in the Medical College of Ohio, in his treatise on the "Diseases of Children and Physical Education of Children" said that colic was frequent and described most vividly its paroxysms of pain. He also noted that it often stopped spontaneously when the child reached three months of age.

Joseph Brennemann in his monumental work on "Practice of Pediatrics" (1948, Vol. I, Chapter 25, page 28) says of colic, "Few infants escape it." His description of colic is masterly—his own children suffered from it—but his treatment does not recognize its simple mechanical cause.

Benjamin Spock in his excellent and currently popular handbook "Baby and Child Care" asserts that although colic or "irritable crying" are not un-

common, we do not know its basic cause. For treatment he too recommends patience.

Fleetwood Churchill, a Dublin practitioner, published "A Treatise on the Diseases of Infants and Children" (Philadelphia, 1850). This is the earliest work that has come to my attention which lays emphasis on the importance of giving the child frequent feedings, small enough to avoid overloading its digestive apparatus (but often enough, and sufficiently concentrated, to provide for its healthy nutrition). On page 40 of his book we find, "The frequency with which the child should be put to the breast varies a little with its appetite. Every two or three hours will not be too frequent."

C. H. F. Routh in his "Infant Feeding and Its Influence on Life" published by William Wood and Co. in New York (third edition 1879), on page 224, said: "We have, lastly, to consider the simple yet important question—How often should a child be fed? In extreme infancy, for the first two months or so, it may be wise to give them their food every two hours."

L. Emmett Holt in his "Care and Feeding of Children," gave a schedule for feeding healthy infants during the first year. This is quoted here from his fourth edition (1907).

SCHEDULE FOR FEEDING HEALTHY INFANTS DURING THE FIRST YEAR

AGE	INTER- VAL BE- TWEEN MEALS, BY DAY	NIGHT FEED- INGS (10 P. M. TO 7 A. M.)	NO. OF FEEDINGS IN 24 HOURS	QUANTITY FOR ONE FEEDING	QUANTITY FOR 24 HOURS
	HOURS			OUNCES..	OUNCES
2d to 7th day	2	2	10	1 -1½	10-15
2d and 3d weeks	2	2	10	1½-3	15-30
4th and 5th weeks	2	1	10	2½-3½	25-35
6th to 8th week	2½	1	8	3 -5	24-40
3rd to 5th month	3	1	7	4 -6	28-42
5th to 9th month	3	0	6	5 -7½	30-45
9th to 12th month	4	0	5	7 -9	35-45

"This schedule gives the averages for healthy children. The smaller quantities are those required by small children whose digestion is not very vigorous. The larger quantities are those required by large children with strong digestion; in very few cases will it be advisable to go above these figures.

"The interval is reckoned from the beginning of one feeding to the beginning of the next one."

My work on this subject was reported in the *Yale Journal of Biology and Medicine*, 1946, Vol.

19, p. 155; 1948, Vol. 20, p. 553, and 1950, Vol. 22, p. 429. This work has led me to several convictions.

1. Physical structures of the digestive tract are responsible for colic. These seem to be hereditary, so that a tendency to colic may appear in several members of the same family.

2. Similar symptoms may be caused by allergies or more serious causes, so that if the symptoms are not rapidly cleared away by feedings adapted to a smaller digestive apparatus, the symptoms should not be ignored.

3. Infants' stomachs and other parts of the digestive tract may vary in size in different infants just as the hands, the feet, the head and the mouth may be larger in some and smaller in others. Attempts to crowd the feet of every youngster into a single size of shoes has long been known to result in discomfort and pain; but, because we cannot see the digestive organs, and because other causes may result in similar symptoms of discomfort and belly ache, we have been slow to recognize the obvious fact that an infant's meal should fit easily into its stomach just as shoes should fit easily on the feet.

If a baby has more food crowded into its stomach than it can properly handle, it will first feel discomfort and perhaps even acute pain. Then it will either vomit up its meal or pass it on into the intestine too rapidly, before it is properly prepared and treated by various digestive secretions. If the latter occurs, the excess of unsuitable material collecting in the ileum of the small intestine will result in pain and diarrhea.

These symptoms can be cured almost immediately by giving a smaller volume of food at each feeding and increasing the number of feedings or the concentration of food or both, to assure sufficient nourishment from the limited volume of the feedings. This is illustrated by the following case records:

CASE 44

Projectile vomiting and enteric colic in an infant one month old, on a formula containing: evaporated milk, 8 oz., water, 16 oz., Dextri-maltose, 3 tablespoons. Total volume 25 oz. given in ten feedings of 2½ oz. each. Changed to a new formula containing: evaporated milk—8 oz., water—8 oz., Karo 2 tablespoons, total volume 17 oz. given in ten feedings of 1.7 oz. each. Note that the formula is practically the same in both feeding plans except for increased concentration due to use of half as much water, and that in both the individual feedings were at two hour intervals. Merely reducing the quantity of water taken in at each feeding—a reduction of 33 per cent of the volume—stopped the colic

and vomiting in two days. The mother's comment was, "It's wonderful what change in a baby a formula will make." Since the only change was in the volume of the feeding, it is reasonable to assume that the colic resulted from the small capacity of the stomach and the ileum.

CASE 17

A girl, one of twins, had had projectile vomiting since birth. She had been on three different formulae in the sixteen days since her birth and her weight had dropped in that interval from $10\frac{1}{2}$ to $6\frac{1}{2}$ lbs. Put on 2 oz. feedings twelve times a day, she stopped vomiting after the first small feeding and gained 13 oz. in a single week. She had to be kept on the two hourly feedings for several months. The inference drawn is that the stomach was congenitally small and unduly stretched by the large feedings.

CASE 30

An infant 11 days old suffering from colic and regurgitation. While in the hospital the baby had been given 3 oz. feedings every four hours. When put on 1.7 oz. feedings every three hours both colic and regurgitation ceased. The mother's comment—"Much more happy." Small feedings were required for a month.

CASE 25

An infant eight days old with colic, vomiting, and diarrhea. In the hospital the baby had received 4 oz. feedings every four hours. When put on one and $\frac{3}{5}$ oz. feedings every two hours the trouble ceased. The inference drawn is that the capacities of the stomach, ileum, and colon were congenitally small.

Perhaps the most convincing evidence that over-size feedings cause colic is in the cases where colic or projectile vomiting have been made to appear and disappear by an increase and then a decrease in the size of the individual feedings. The following cases are illustrative:

CASE 4

Infant had been on 3 oz. feedings. Feedings were reduced to 1 oz. necessitating, for only a short time, nineteen feedings a day. After colic had disappeared the amount was increased by the mother to $3\frac{5}{7}$ oz. Relapse to colic followed immediately. When decreased to $2\frac{1}{5}$ oz. the colic ceased again.

CASE 81

Colic. The infant had been on 8 oz. feedings. When put on $3\frac{1}{4}$ oz. feedings the colic ceased. When, subsequently, the mother increased the amount to $4\frac{4}{7}$ oz. a relapse occurred. When returned to $3\frac{1}{4}$ oz. the colic stopped within three days.

CASE 26

Colic. Had been on $4\frac{1}{2}$ oz feedings. These were reduced to $1\frac{3}{4}$ oz. for a month with three hour intervals. This was successful; but when put onto a four hour interval the baby screamed and "filled up with gas." A return to the three hour intervals was successful. Under the generally accepted treatment, many cases of colic persisted because, while

numerous formulae have been tried, all were of a volume too large for the small capacity of the stomach or ileum.

CASE 38

Five months old, this baby had been on five formulas, all at four hour intervals. When the volume was reduced from 5 oz. every four hours to $2\frac{4}{5}$ oz. every 2 hours, vomiting and crying stopped. When the baby slept peacefully the first night of this treatment the father got up twice thinking that the baby must be dead. The baby gained fifteen ounces the first week. Diagnosis: small capacity of the stomach and ileum.

It would appear that at least as large a percentage of premature infants have abnormally small capacity stomachs and/or intestines as do full term infants. Diagnosis should be made as soon as possible. In such cases concentrated feedings should be given every hour or so without moving the baby. So treated, premature twins (boys) weighing 2 lbs. 8 oz. and 2 lbs. 12 oz. gained, respectively, 78 per cent and 58 per cent in forty-two days without any setback.

Dr. L. Emmett Holt, in an article in "Archives of Pediatrics" published in 1890 (p. 963), demonstrated that while the infant's body is growing to double its weight, the stomach capacity quadruples. It is this which accounts for the spontaneous disappearance of colic after about three months. By that age the stomach has grown enough to take care of the larger meals.

Not only the stomach but other parts of the digestive system as well may be congenitally undersized.

To the food and water taken in through the mouth, gastric juices, bile, pancreatic juice and other digestive secretions are added before it reaches the lower end of the small intestine, known to doctors as the "ileum." The outlet from the ileum into the large intestine is through a muscular "drawstring" valve, known as a "sphincter," which controls the flow of this mixture. In those cases where the ileum or the ileocecal sphincter is too small, the infant experiences sensations ranging from feeling of discomfort to agonizing paroxysms of pain. These are the cases which are most spectacularly relieved by small frequent feedings. Most babies, when fed with proper quantity and quality and at proper intervals, have no trouble. Some, however, inherit stomachs or ileums of too small capacity or too tight sphincters.

Cases of "enteric colic" are much more common than is generally recognized; and much more can be done for such cases than the literature discloses.

The pain which many babies suffer and the nervous exhaustion of parents who are constantly worried by the obvious discomfort and continual crying of these babies are unnecessary.

Letters from the mothers of colicky babies relieved by this treatment are eloquent:

MARK B.

"He was six weeks old when you first saw him. He had the usual symptoms of colic. Had diarrhea so badly that I often could not change a diaper before another discharge. It was almost constant and resulted in dehydration so complete that the doctor told me that he could not have lived another 24 hours without treatment. (He had been fed every four hours.)

"My reaction to the decrease in volume was that we had enough trouble and that now I would most certainly lose my only son.

"Three days or less stopped my worrying. I had a happy contented, gurgling baby. I think he was one of the most contented babies I have ever seen."

The baby was born March 5, 1943.

At six weeks of age, his feeding was changed to 2 ounces every 2 hours of the following formula:

Carnation evaporated milk.....	7 oz.
Dextri-maltose	2½ oz.
Water	2 oz.

A very ordinary formula except for the reduced volume of water.

Beginning the next day after this change, he had no vomiting or colic. From May 24 to May 31 he gained 1 lb. ½ oz.

TOMMY R.

"He was over-fed in the hospital. As a result he had projectile vomiting. When he was home he continued on a four hour schedule. Fussed at night. When Mary gave me your article (in *The Yale Journal of Biology and Medicine*) we were desperate and worn out. After reading the article I began nursing Tommy two minutes by the clock every two hours. The vomiting stopped and the daytime fussing dropped to normal. I am sure it was the short frequent feedings which helped. If I let him nurse for longer periods the uncomfortable fussing would return. Needless to say we will always be grateful that your help came when it did. If I had continued to stuff him his babyhood would have continued to be miserable and I would have been a wreck.

"Sincerely,
"M.R."

So many of our ills and pains are due to infection and such great success has been had in controlling them that we tend to think of medical treatment as a matter of pills, capsules and inoculations; but colic in infants is not due to infection and no such treatment has been found to be effective. Most mothers have also been made keenly aware of the import-

ance of nutrition—proper amounts of carbohydrates, proteins, vitamins and minerals; but colic is not basically a dietary deficiency (although excessive vomiting or ineffectual digestion can result in deficiencies). It is essential to the proper treatment of colic that both the mother and the physician recognize that the cause is in the inability of perfectly healthy digestive organs to function properly when overloaded.

The idea that colic is a mere incident of early infancy which will pass in a few months and should therefore be ignored is false and dangerous. Those months are a time of rapid growth of essential parts of the body. Interference with the supply of the nutritive elements of growth certainly will impair to some extent the perfection of the child's body, and perhaps even its mind, and has shown serious emotional consequences in some cases. Finally, because the symptoms of colic may resemble those of allergies and even more serious illness, a nonchalant attitude toward colic may cause a dangerous disregard of these more serious conditions.

With the simple and effective treatment described, one can quickly clear away the cases of colic and so call attention to the more serious conditions which require a different treatment.

We cannot change the anatomy of the digestive tract to enlarge the capacity of the stomach or the ileum, but we can change the amount and frequency of feedings to come within the natural capacity, whatever it may be.

The author is indebted to Dr. Donald H. Barron of the Department of Physiology of Yale University School of Medicine and Dr. John A. Brobeck of the Department of Physiology, University of Pennsylvania School of Medicine for their helpful consideration of this paper and their encouragement toward its presentation. Dr. Barron's encouragement more than ten years ago led to the publication of the author's previous papers in the *Yale Journal of Biology and Medicine* and he has reviewed this paper and encouraged its publication.

Dr. Brobeck, after reading this paper, states that in his opinion the ideas expressed here are in good agreement with what is known of the physiology of the stomach and bowel and he suggests that the subject is of such importance that it deserves greater experimentation and study than it has received in the past.

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THE INTERMITTENT, ACUTE TYPE OF PORPHYRIA HEPATICA

Case Report

ALFRED W. WOLFSOHN, M.D., *New Haven* and PHILIP MORGENSTERN, M.D., *Newington*

THE term porphyria has been generally used to connote a peculiar constitutional fault or "in-born error" of porphyrin metabolism characterized by pronounced over-production of uroporphyrins and related substances. Porphyria has been classified as follows: (1) porphyria erythropoietica, also known as congenital and photosensitive porphyria; and (2) porphyria hepatica. Subdivisions of porphyria hepatica are: (a) intermittent acute type, and (b) mixed types—which are photosensitive at times and have abdominal and nervous manifestations at other times. It is thought that porphyria erythropoietica mainly involves abnormal porphyrin metabolism in the bone marrow, while in the hepatica form the pathological findings are mainly in the liver. The erythropoietic form of the disease is distinctly rare. The hepatic form is uncommon but with greater awareness on the part of the clinician it is found more prevalent than was previously thought, Waldenstrom having already seen 143 cases of it in 1939. The importance of getting a complete family history and the unusual manner in which this particular one was uncovered is illustrated by the following case.

CASE REPORT

Present illness: This 23 year old, single, Negro veteran of the Korean War, was admitted to the Newington Veterans Administration Hospital with the chief complaint of 50 pound weight loss in the past three months. (Figure 1.) The patient had been admitted to the St. Francis Hospital in Hartford, Connecticut on March 10, 1956, and at that time had complained of intermittent abdominal pain, mainly in the midepigastrium. There was no nausea, vomiting, hematemesis or melena. A routine urinalysis showed dark amber urine on March 18. Various x-ray studies ruled

Dr. Morgenstern. *Assistant Chief of the Medical Service of the VA Hospital, Newington, Connecticut*

Dr. Wolfsohn. *Resident in the Medical Service at Grace-New Haven Community Hospital, New Haven, Connecticut*

SUMMARY

1. A case of porphyria hepatica, intermittent, acute type is presented where two other members, and possibly a third, also had the disease.
2. All other members of the family had a similar group of symptoms consisting of abdominal pains which led to laparotomy, peripheral neuropathy progressing to quadriplegia, vocal cord paresis and psychiatric disturbances ranging from extreme nervousness to hallucinations and delusions.
3. The difficulties in differential diagnosis are noted.
4. The difficulty of securing an accurate family history in fatal familial disease because of repression on the part of the patient is illustrated.

out perforated ulcer but it was felt that the patient had an obstruction of the distal end of the stomach which finally led to operation on March 31, at which time "lysis of congenital duodenal bands about the first and second portions of the duodenum" was performed. The patient had been given barbiturates on admission and this was continued during part of his course. It was noted postoperatively that the patient could not talk except in a whisper, and on visualizing his vocal cords they were found to have impaired adduction. This was attributed to either hysteria or anesthetic trauma to the cricoarytenoid. The patient's postoperative course otherwise was unaltered. He continued to lose weight, vomited everything he ate, and necessitated

From the Medical Service, VA Hospital, Newington, Connecticut

feeding almost entirely by vein. He was discharged from St. Francis Hospital on April 2 and re-entered on May 2 because of persistent hoarseness. It was felt that nothing further could be done for him and he was again discharged, and four days later was admitted to the Newington Veterans Administration Hospital with the following symptomatology: (1) further weight loss down to 113 pounds as compared to his normal 160; (2) hoarseness not improved; (3) development of pains in the right forearm and weakness of the right arm.

The patient's past history contained the following pertinent fact. He was a student by occupation. He drank alcohol only occasionally at parties. He used no drugs. When questioned about his family history, he stated that he had two siblings living and well and that his parents were likewise in good health.

Physical examination: On May 10, height 5' 9", weight 113 lbs., temperature 98, pulse 76, blood pressure 122/84. The patient was a well developed but poorly nourished, Negro male who showed signs of considerable weight loss. Positive findings were confined to the abdomen and neurological systems. The abdomen showed voluntary muscle rigidity and a scar of recent operation. Liver and spleen were not felt. There was tenderness over the right forearm. The cranial nerves were intact. Biceps and triceps reflexes were hypoactive in the upper extremities. Knee jerks were absent but ankle reflexes were definitely present. There were no pyramidal tract signs. There was patchy hypesthesia over the skin of the legs, otherwise no sensory changes. There was definite muscle weakness in the right arm and right hand which he could not close. His voice was reduced to a whisper.

Laboratory data: Admission blood count showed hematocrit of 42, hemoglobin 81 per cent, sed. rate 28, white blood count 13,500 with normal differential. Urine was described as dark amber on two occasions with albumin 1 plus on three occasions, sugar 1 plus on one occasion and 3 plus on another. NPN at time of admission was 44 mg. per cent, but on subsequent tests came down to 31 mg. per cent. Fasting blood sugar normal range on four occasions. Calcium 9.9 mg. per cent, sodium 147 and 150 m.eq./liter, potassium 4.4 and 3.8 m.eq., chlorides 110 and 96 m.eq., CO_2 34 m.eq./liter. Two stools for blood were negative. Liver function tests: prothrombin time 55 per cent of normal, icterus index 11.6, total bilirubin 1.1 mg., direct 0.4, indirect 0.7. Total protein 5.4 Gm, albumin 2.5, globulin 2.9, cholesterol 320 mg./per cent, cephalin flocculation negative, thymol turbidity: 1 unit.

X-rays of chest, upper G.I. tract, radius and ulna reported as negative.

Clinical course: Since as a result of the initial survey at this hospital no definite diagnosis could be made, it was felt that the patient probably had conversion hysteria. On one or two occasions he was found able to move his right arm although he complained of paralysis. The peculiar whispered speech, extreme anorexia, and bizarre abdominal pain also inclined the staff towards a diagnosis of conversion hysteria. His paralysis progressed from his right arm into the left arm and into his lower extremities.



FIGURE 1

On May 23, 1956, while under the influence of alcohol, the patient's father told the night nurse that his daughter had died at the Hartford Hospital several years ago of an obscure illness. It had many features resembling that of the patient's. It should be noted that this information had been repressed by all members of the family and the father admitted that he could not keep it to himself any longer. It is interesting that the patient had denied all information

about the death of his sister and the peculiar color of his urine which he had noted. He was well aware that he was suffering from the same malady. The Hartford Hospital was contacted and it was determined that the patient's sister had died of porphyria. The next day the patient's urine was tested for porphyrins and was found to be positive. All subsequent urines similarly were positive. The patient was placed on ACTH 80 units daily and began to eat and feel better for a few weeks. His quadriplegia and whispering remained unchanged. His weight steadily went down, however, despite high protein and high fat feedings. He continued to feel best after Hubbard tank and muscle stimulation therapy, but his muscle mass continued to waste away and he expired on July 8, receiving oxygen at the end. It was felt that he died in respiratory failure.

Family tree: Porphyria is described as being a Mendelian dominant. It may be latent in its expression and thus latent porphyria is a definite term. We have the following information on this patient's family. One sister died at age 17 in 1947 of porphyria. This case will be summarized below. The patient has two other siblings. One brother of the patient was tested and his urine was found to be negative for porphyrins. The mother died in 1936 with a final diagnosis of (1) acute exacerbation of salpingitis; (2) encephalomyelitis, type undetermined, but as will be seen below, this most likely was porphyria. The patient's maternal grandfather is described as having had voice changes and quadriplegia during his terminal illness. This might well have also been the result of this disease. A maternal aunt was tested for urinary porphyrins and found to be negative. The father had a negative urine and no one on his side of the family has had any illness resembling porphyria.

1. Summary of R.M.H., the patient's sister: Admitted to McCook Hospital on December 14, 1946 and discharged on April 20, 1947; dead on admission at Hartford Hospital on April 21, 1947. The patient was a 17 year old colored female who entered with a chief complaint of loss of weight of 40 pounds in three to four months prior to admission, associated with anorexia, amenorrhea of two months duration and extreme nervousness. The patient had had an emotional upset prior to admission, and intermittent abdominal pain and feeling of nausea. She had been operated on three months earlier at a local hospital and had an appendectomy for "chronic fibrinous appendicitis." For some time prior to this she had had severe weakness and anorexia. For one week postoperatively she had red-wine urine. Clinical course showed that she became steadily weaker, lost the use of her arms, and that all her symptoms increased after admission. A urine was found to be normal when first passed, but sunlight turned it burgundy-red. White cells, red blood cell casts and albumin 1 to 2 plus were found on urinalysis; the diagnosis of porphyria was made. The patient also had bilateral foot drop and splints were applied. Physical examination revealed again that all reflexes were inactive except for the ankle jerks. There were no deep tendon reflexes. Laboratory tests that were positive were cephalin flocculation of 4 plus after 24 hours and urine that was described in color as pink to port wine. Autopsy performed at Hartford Hospital on April 22 showed the following in the summary of gross findings: (1) porphyria; (2) gastric and duodenal dilatation; (3) congenital anomaly of lungs;

pleuritis, healed; fibroadenoma of the right breast; and marasmus. The brain, which was examined at Montefiore Hospital in New York City, was described as negative on gross and microscopic examination.

2. Case history of H. H., mother of the patient, admitted September 8, 1936 to Mt. Sinai Hospital in Hartford. Date of demise, September 19, 1936.

This is a 24 year old, married, colored female who entered with a chief complaint of pains in the abdomen and pelvis. She had had these pains since her appendectomy two years prior to admission. She had a premature delivery one year prior to admission and excessive menstrual periods after that. She had menstruated throughout most of her pregnancy. On physical examination her abdomen showed rigidity in the lower left and tenderness in both lower quadrants. The urine was described as wine-colored. There was a slight trace of albumin and trichomonas vaginalis was found in the urine. The sedimentation rate was described as moderately rapid. Hemoglobin was 81 per cent, WBC 13,000 with normal differential. The patient had abdominal pains so severe that they were not relieved by medication. A few days after admission she became irrational, requiring restraints. After one week she developed hallucinations and delusions, increasing weakness of the extremities and voice. The temperature never rose above 101. The patient had a neuropsychiatric consultation and she was described as having flaccid paralysis and able to speak only in a whisper. She was disoriented to time and place. There were no sensory disturbances. Radial and patellar reflexes were not obtained. The consultant felt that "in view of the reported mental symptoms, and inconsistency of neurological signs, a functional disturbance must be kept in mind." It was his impression, however, that the disease was more likely organic. The patient was diagnosed as having (1) acute exacerbation of salpingitis; (2) encephalomyelitis, type undetermined. She continued her downhill course and expired soon thereafter. No autopsy was obtained.

DISCUSSION

In porphyria hepatica the liver rather than the bone marrow is principally responsible for the abnormal porphyrin formation. The commonest type is the intermittent acute type. It is manifested by abdominal and/or nervous symptomatology. The abdominal pain is colicky, generalized or localized, simulates appendicitis, bowel obstruction, perforated ulcer, renal or biliary colic, or pancreatitis. Fever and leukocytosis are unusual, and it has been known that barbiturates precipitate the attacks, as may alcohol, and both cause an increased excretion of porphyrins in the urine. X-rays often show distended areas of bowel with trapped gas. The neuropsychiatric symptomatology can be broken down into (1) peripheral neuropathy; (2) bulbar signs, and (3) psychic changes; and (4) autonomic changes. Under peripheral neuropathy we have painful extremities, flaccid paralysis, often quadriplegia with different sequence of extremities becoming

involved. One of the curious contrasts in this illness is that the ankle jerk may be prominent in the absence of patellar reflexes. There are few sensory changes. In the bulbar form, which is seen in severe cases, one can find respiratory paralysis, and also difficulty in swallowing. Vocal cord paresis with a weak or high-pitched voice is not uncommon. Psychic changes in this illness are described as pseudo-hysteria and these patients are often excessively nervous, even before attacks. The autonomic changes consist of pigment deposition in the ganglia. This may account for the abdominal pains. The treatment of this disease is limited. Barbiturates and alcohol are definitely contraindicated; paraldehyde, chloral hydrate and opiates seem to have no adverse effects. ACTH has been administered in doses of about 40 mg. intramuscularly every eight hours and has been found in some cases to bring about a remission earlier.

This case illustrates several interesting features. The disease was present in at least three and possibly four members of a family, and in each of them the constellation of symptoms was strikingly similar (vocal cord paresis, abdominal pains and weight loss, peripheral neuropathy progressing to quadriplegia, and psychiatric disturbances ranging from extreme nervousness to delusions and hallucinations).

The fact that each of these three patients had undergone previous abdominal surgery, and that each was believed to have primary psychiatric disease, re-emphasizes the difficulty of diagnosis of this condition.

It is obvious that a complete history including family data is particularly important in diseases with familial tendencies. However, even after the most thorough questioning, one can be thwarted by the natural repressive mechanisms of the patient who suspects that he is suffering from a malady which has proved fatal to other members of his family. Such is the case of our patient who, consciously or unconsciously, "forgot" to mention his older sister's disease when asked about his family history.

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DO WE MEAN WHAT WE SAY?

"Goodbye, George! Give me a ring tomorrow."

How often we hear such words as friends part. We are not in doubt as to their meaning, but possibly we can imagine the bewilderment of a European or Asian visitor whose knowledge of our language does not include its current idioms. "What kind of ring is this (one can imagine his asking) which his friend demands of George? Why must he receive it tomorrow? . . . Oh, he is asking his friend to telephone him? But why can't he say so?"

The bewilderment of our visitor would not be lessened upon hearing one person say to another: "Send me a wire from Chicago." He would doubtless wonder what kind of wire was desired, what purpose it would serve, and why it must come from Chicago. Upon learning that the word wire meant telegram, he might logically inquire if the word telegram has some shameful implication that prevents its use in polite conversation.

In terms of frequency, the phrase "Drop me a line" probably stands on a level with "Give me a ring." If spoken by a man who had fallen into a well it would be understandable, but why have presumably logical people adopted this queer phrase to mean: "Send me a note"? Just how does one drop a line from Miami to New York?

When George has given a ring or sent a wire to a friend, he might include such instructions as: "Take a taxi from the station to the Universal Building, then take the elevator to the 26th floor, where I have my office." Is this a modern Paul Bunyan who can pick up a taxicab and carry it to the building, then pick up an elevator with his free hand and carry it up 25 flights of stairs? "Oh no," we patiently explain to our frustrated visitor, "the message means that the taxi and the elevator are to carry the man; Americans have simply learned to say it in reverse."

Not infrequently we read in reputable books and magazines that "the man was so angry that he was beside himself." Is this a form of double vision suddenly conferred upon the beholder, or does anger

H. M. MARVIN, M.D., *New Haven*

The Author. *Literary Editor of the Journal; Associate Clinical Professor of Medicine, Yale University School of Medicine*

enable a person to duplicate himself and become identical twins momentarily? The man was beside himself? Let the reader try this in the privacy of his own home without the aid of mirrors.

Both medical and nonmedical people are likely to describe an episode of fainting by saying: "The man fainted for about five minutes, then came to." Came to what? The speaker undoubtedly thinks he has indicated clearly that the man recovered consciousness after five minutes. But do his words actually say this? Perhaps we should ask ourselves if the phrase "came to" has a legitimate place in the description of such attacks.

We speak of going to the theatre or taking a trip "now and then," but how often is that? We may say these words while sitting at home, in which case the word "now" is clearly inappropriate. This common phrase does not even have the justification urged for many substitutions, namely, a saving of time, for these three words are used as the equivalent of the one word "occasionally."

How spectacular it must be to watch a man "take his life in his hand"! This extraordinary accomplishment has been recorded so often that scientists must now have a clear idea of what life looks like, especially when concentrated in a mass so small that it can be held in one hand. Are there some who share my eagerness to see a demonstration?

These remarks are not intended as a plea for precision and formality in speech, for language would lose much of its color, charm, and beauty if a single idea could not be expressed in various ways, some of them possibly puzzling when first encountered, but usually meaningful to those for whom they are intended. If these comments irritate some readers and they wish to express their irritation, they are urged not to send me a wire, drop me a line, or take a taxi to my office. Just give me a ring!

NOTES FROM A EUROPEAN DIARY

RUSSELL V. FULDNER, M.D., *New Haven**Barcelona March 1956*

In laying claim to Columbus, modern cities contend like those of ancient Greece over the birthplace of Homer. At least three cities in the old world, two in the new, stress their distinctive relation to the great navigator: Genoa, his birthplace; Santo Domingo and Havana, where his bones successively rested; Seville, at least by Sevillians accounted his present burial site; and Barcelona, whither Columbus journeyed after his first voyage to America, to be ceremoniously honored by Ferdinand and Isabella on a scale befitting his high achievement. Where Barcelona ranks among her sister contenders is a matter of opinion, but to strolling sightseers one fact is as evident as altitude can make it: Barcelona's statute of the Admiral, atop an immense pedestal overlooking the harbor, can scarcely be other than the world's highest. Reckoning esteem by the foot, Barcelona must cherish Columbus more than any place on the globe.

Its heroes aside, visitors like Barcelona for the run of citizens—cheerful, personable, *simpático*. In spite of its dominant commercial position in Spain the city manages to maintain a pleasantly relaxed attitude toward affairs. Most business places lay aside operations two or three hours every afternoon for purposes of recuperation, and the visitor who imagines he has important matters to transact during the siesta soon learns—by dint of fruitless rappings on locked doors—to adopt a more seasoned outlook on life. The cafés, almost alone among the town's enterprises, keep doors open during the midday let-down. Workers who cannot reach home in time for a rest take it instead at their favored café, meeting and talking with friends, writing letters or sitting for a couple of hours over a thimbleful of coffee. Barmen and waiters appear resigned to the use of their establishments as public clubs; at any rate, they never press patrons to order anything. Keeping to such reasonable perspectives, Barcelona yet gives no impression of lethargy. Its shops are smart, well

stocked with up-to-date goods, the business folk alert; and for all the city's midday stretch its citizens can be seen hustling about their affairs long after nightfall.

With the aid of some recently renovated Spanish we ascertained that the Simca, a French car purchased in New York—out of a catalogue—for delivery in Barcelona, had failed as yet to put in an appearance. An explanatory telegram from Paris vaguely referred to “atmospheric conditions.” The car agent in Barcelona took the long, consoling view, asserting it to be a well known fact that automobiles always arrived eventually. Anxious to include an excursion to Montserrat in our schedule, we took off by bus in the hope of being favored by an atmospheric remission before we got back.

Montserrat—the name means saw-tooth mountain—is perched on the edge of a precipitous cliff overlooking the valley of the Llobregat, a winding river that rises high in the Pyrenees and finds its way to the Mediterranean a little south of Barcelona. In another setting the monastery buildings might be passed over as merely well endowed; here, with their outer walls continuing the cliff's upward thrust, they seem as much symbol as sanctuary, the spirit's reach revealed in a tangible dimension. Towering above the church, the famous music school and library, the lodgings for monks and pilgrims, are peaks of bare rock in massive rows and ranges. It is these which give Montserrat its name. Occasionally they are banked like the pipes of a gigantic organ loft, and indeed the surroundings are such that an earnest pilgrim might succeed, sooner or later, in catching echoes of a divine music from these very stones. The monks will let you stay at Montserrat a few days if you wish to try the experiment. . . . We got back to Barcelona to find the Simca still unreported. With no choice but to proceed as best we could without it, we decided to go to Majorca by boat, planning another return to Barcelona later.



Montserrat: *Heaven haven*

Majorca

The Barcelona-Palma ferry, newly built in the Valencia shipyards, turned out to be a sizable vessel, with first and second class dining rooms, a bar decorated in breezy modern style, and comfortable cabins. Following a smooth overnight voyage we disembarked in Palma so early that after one breakfast on board ship we arrived at the hotel in ample time for another. One shore of Palma's broad harbor, the northern, is rimmed with hotels, located to court the sun and crowded at the time of our visit with European tourists vainly waiting for the sun to respond. To most of the tourists—they came principally from England, Scandinavia and Germany—the climate of wet and chilly Palma must have seemed little improvement on home. ("Very unusual weather for this time of year," according to everyone connected with the hotel business.)

With the help of a hired car and a very obliging chauffeur we used one day of our brief stay in Majorca for exploring the northern part of the island. This is mountainous terrain, where high and sharply twisting roads leave you a little short of breath, even in an automobile. The driving hazards at any rate helped salve our deprived feelings anent the Simca. For a time the Palma-Soller road

runs on a ledge high above the sea, with a sweeping vista of the Mediterranean, overlooking weedy remnants of a carriage drive built along the shore long ago by a Hapsburg archduke as part of his snug, scenic abode. Inland lies Valldemosa, Chopin's monastic retreat in the hills, with his cell "the shape of a tall coffin." On the day of our visit, which was chilly and overcast, the place seemed thoroughly uninviting indoors and out. This was also Chopin's opinion of it, as well as the conclusion reluctantly reached by George Sand, who had conceived their trip to Majorca but was obliged to write that "our stay was a torture for him and a torment for me." They made their way back to Paris as soon as spring weather permitted travel. . . . Unlikely-looking farm country, the stony slopes of northern Majorca nonetheless yield large fruit and olive crops. The arable land consists of a profusion of tiny terraces wrested in the course of centuries from the begrudging hillsides. Hand built, the terraces will probably continue to be hand worked until the end of time, local topography not being conducive to any prosperity whatever in the tractor industry.

For variety's sake we returned to Barcelona by plane: an hour in the air and a *copa* of first-rate sherry at the inclusive rate of 245 pesetas—about

\$6.25. Aboard, the sherry and the fact that a few of the seats were lacking safety belts contributed to a cozy sense of informality a little out of the ordinary in aircraft. The safety belts didn't much matter though, since the plane took off before all the passengers sat down anyway. . . . We rejoiced to find the Simca awaiting us in Barcelona. Discounting our readiness by then to accept any vehicle that could roll, or perhaps even be pushed, the Simca still looked worth waiting for, sturdy and neat, a little smaller than an American sedan of a few years ago. Included in its equipment were warning lights for low *essence* supply and ignition trouble, as well as an admirable two-toned horn, one voice (*pour la ville*) gently persuasive, the other (*pour la route*) insistent yet not ill-tempered. Loud or soft, the horn sounded reasonable and civilized, putting its strident American counterpart to unflattering comparison.



Valencia: *in man's image*

Valencia

Reaching here on St. Joseph's Day, March 19—a sort of Fourth of July, Halloween and religious holiday all wrapped in one—we were promptly told that hotel rooms had trebled in price and, for consolation, were unobtainable in any case. (This was almost the only time that any difficulty developed

regarding accommodations in Spain—or in Europe for that matter, the season being early). The center of Valencia, teeming with merry-makers, was in the throes of a traffic jam, a sight suddenly reminiscent of home. It was mostly outlanders like ourselves that composed this crowd, so we drove farther afield, searching out the ways and means of authentic homage to St. Joseph. The Valencians, it developed, love their patron vociferously. Each neighborhood was on its own, with parades, bands, firecrackers and abundant supplies of *buñuelos*—hot cakes. While crowds of people overflowed everywhere they were jammed practically to a standstill in the streets opening on the district *falla*, a giant, elaborately contrived figure of papier-mâché or plaster on a board frame-work. The *fallas* are traditional for St. Joseph's Day. Of satirical intent, they delight in linking lofty pretense with comic issue, and in grandly portraying heroic undertakings of no consequence whatever. The explanatory—or derogatory—captions are written in a Catalan tongue, one seemingly archaic enough to give pause even to Valencians, let alone American sightseers. If any ambiguity results there is perhaps as much to be gained as lost; politicians are often the butt of the joke and in this country a certain vagueness in political commentary marks the prudent man. The *fallas*, we were told, would be burned amid a last outburst of festivity at midnight, an event which, believing the first concern of tourism to be a bed for the night, we did not stay to witness.

Granada

Southeast Spain is steeply mountainous country, as we discovered in the long high climb from the coast to Granada. After leaving Murcia we drove along a road of ascending loops through unpopulated hills of desolate and incinerated aspect, with snow flurries becoming frequent at higher altitudes. On the final rise into Granada the snow was deep enough to mire several cars that had strayed too close to the road edge. The Simca took grades and snow with unconcern, more than could be said of its passengers. . . . Granada, long ago the last Moorish capital in Spain, lies encircled by hills in a vast green basin, the snowy peaks of the Sierra Nevada in the near distance. The Moors were in the south of Spain for about eight centuries, leaving behind them a legacy of darker complexions and broader faces than one sees in the north. Perhaps more celebrated is their legacy of the Alhambra. This one-time fortress, administrative center, pal-

ace, harem and pleasure dome must be imaginatively viewed today, since it is mostly the bare bones of former grandeurs that remain to confront the visitor. When Washington Irving visited Granada in 1827 the buildings and courtyards of the Alhambra had long been serving as a den for gypsies and tramps, and were sadly decayed. Reconstructive efforts, begun soon after Irving's visit, have been continued at intervals since. Even though much of the richness that marked the Alhambra's great days has gone forever, fled with Boabdil, the visitor is plentifully rewarded by the delicate architecture of interior courtyards, with their arches and colonnades, by exquisitely worked ceilings, perhaps most of all by a subtle feeling of proportion. Here and there figured tiles, intricate wood carvings, a patch of restored mosaic, hint of departed lavishness. Adorning a number of the walls are elaborate decorations of calligraphic stucco, among their inscriptions the one verse, endlessly repeated, that prophesied better than the builder knew: "*Only God is victor.*"

In Granada, as elsewhere in Spain, an unobtrusive and prevailing friendliness is one of the country's great charms. The traveler who stops to ask his way inevitably occasions a neighborhood conference. While those authorities who have been so far as the next town are naturally accorded chief respect, everyone insists on contributing to the discussion, a spokesman finally rendering the consensus. All of this necessarily springs from a pure desire to be friendly, because the chances are that just one road leads to where you're going anyway. The obvious is irrelevant; it is manners that count. True, there is always the uncle in New York or brother in Detroit who must be inquired about. Surely the *norteamericanos* have run across him? . . . Some pursuits, one supposes, a Spaniard engages in all by himself; but this can be offered only as conjecture. It is rare to see anybody going about his affairs in provincial Spain without an assistant, companion, hanger-on or at least someone to talk to. In the case of country folk these needs, including the conversational, oftentimes seem to be supplied by a mule or burro. The dog tagging along behind them must also make a vital contribution, since he is always there.

Algeciras

The fine art of doing nothing in particular can be learned with only slight application on the

terrace of the Reina Cristina Hotel here, especially in late afternoon as green palm fronds slowly turn to black silhouettes against the sky. Two and a half miles across Algeciras Bay, looming bulkily in the dusk, is the rock of Gibraltar, its street and house lights like luminous fleas on a half submerged rhinoceros. Gibraltar accords the tourist a welcome of unusual warmth, quite a few of the natives being willing, even anxious, to embrace you on sight—so long as you come provided with bananas or peanuts. These are the Barbary apes, whose tenure of the Rock, so the legend goes, is to endure as long as England's. Among the other inhabitants there are those who will drive you about for a reasonable fee, showing off the town and restricted parts of the naval establishment, along with items of special interest like the vehicular tunnel drilled through the Rock during the last war, and the immense rain catchments on the hill slopes that supply Gibraltar with its water. While life on the Rock may strike an outsider as parochial, the British colonials seem to think it satisfying enough—at the same time intimating that one is faced with a sorry range of choice, the state of the world being what it is—certainly entertaining no wish to trade their status for that of Spanish subjects. On various occasions, some recently, Spain has let it be known that she would consider the changeover a tactful gesture for England to make. The apes have yet to evince any intention of leaving.

With its fishing boats in harbor, and North African consignments piled on the quays, Algeciras presents the appearance of animation, especially mornings when the waterfront is thronged with fishermen and housewives are making their way to market. The town is perhaps more busy than prosperous; its public buildings have a down-at-the-heels look and the store displays, a sensitive gauge of community fortunes, are dull and utilitarian. An exception should be made of the vast food market, utilitarian but far from dull. The market is made up of innumerable stalls, housed under a gracefully arched sheet metal shed the size of a circus tent, where heaps of tempting delicacies are displayed: freshly-skinned goats (the fur pelts hanging by the carcasses suddenly explained the bound-for-Antarctica dress of many of the smaller children); coils of black sausage; fish, vegetables, cheeses, casks of black olives. On most items maximum prices are fixed and posted by the government.

Jerez, Maundy Thursday

Jerez's relation to sherry is as Rochester's to Kodak, except that Jerez—the region at least—has no competitor worth naming; if it's sherry it's from here, and prosperity has become a local tradition. Driving through this section of Spain in the spring, however, the visitor sees as much of wheat, rice and olives as of grapes. Around Jerez the terrain is of rolling character, beautifully green; near the coast it drops off into the tidal flats of the Guadalquivir delta, where sloping hillocks of evaporated salt rise near the water's edge, like nomads' white tents on a prairie exposed by the sea.

The mood of Jerez during Holy Week might be mistaken for one of carnival instead of contrition. When the evening religious processions are on crowds of people in Sunday best move restlessly along the sidewalks, as much occupied with observing one another as in looking at the marchers. Everyone spills into the street as soon as the processions end, and the remainder of the evening is occupied by a secular parade, the decorative sex as chief participants. The women of Andalucia possess old but engaging resources of dress—high tortoiseshell combs, black lace mantillas, shawls half carried, half worn—and seem without exception beautiful.

During the religious processions the Virgin is carried, high and sedate, on the shoulders of the faithful. She glitters with jewels and resplendent robes, trailing an immense scarlet and gold mantle which dozens of anxious hands carefully hold out of contact with the ground. Other sacred figures, less dazzling, follow along slowly, aloft on heavy platforms. Bare feet supply all the motive power; twenty or thirty pairs to a platform, they protrude below the edge of the dark draperies that otherwise conceal the bearers. Now and again all feet stop at once, as the platform supports are rested on the ground; a sharp rap on the wood sets them off again. Bands of music accompany the saints in their slow advance, as well as contingents of masked mummers—chiefly schoolboys in high delight with their roles—sporting immense conical hats and brightly colored capes. In their hands the mummers bear long candles, flames flickering in the wind, apt symbols of evanescent mortality amid an immortal host.

Cordoba

This seems the place for a detached note on Spanish cookery, the just-finished and quite magni-

ficent Palace Hotel here holding to a French cuisine. However resolute one's intention to take the country as it comes, repeated bouts of olive oil cooking, at least in its more undisguised aspects, are apt to weaken both will and digestion. The roaming tourist can easily do worse than purchase a few biscuits and canned sardines in town and make his wayside lunch of these, along with a bottle of wine and one of the excellent Spanish cheeses. Cities and larger towns usually have eating places of fair to good quality; in selecting a spot for his evening meal the traveler will do as well trusting to instinct—or his nose—as to guidebooks. While a city like Barcelona may feature a few superb restaurants, those in smaller towns tend to the unimaginative, their fish dishes as a rule of more interest than any prepared with the local meats. As for the talents of Spanish bakers, no friend of Spain would wish to dwell on the subject. In the brewing industry competition is not encouraged, no doubt accounting for the flatness of the few brands of beer available. Applied to the startling mixtures served for cocktails, however, flatness were a term of high praise. All things considered, the tourist will nonetheless manage to dine satisfactorily more often than not, and nearly always at a low cost. In most places dinner, begun around nine in the evening, finishes close to midnight, given a small circle of friends and a few helpings of the *vino de la casa*.

To return to Cordoba: When Charles V visited here in the sixteenth century he was unhappy to find his subjects putting up a cathedral within the great mosque which had been erected by the Moors hundreds of years before. It was Charles' lament, perhaps because Europe had just emerged from its great cathedral-building centuries, that "what you are building is everywhere and what you had is nowhere." Whether or not saved by the royal plaint the mosque, for the most part, was allowed to remain intact, the cathedral still being carried to completion. Splendidly anomalous, arrogantly Christian, it stands today in the midst of a vast stone nexus of Arabic vaults, pillars and double arches. This illogical, captivating architectural melange, Cordoba's chief pride, is one of the great rewards of a trip to Spain. In addition to its cherished *Mezquita*, Cordoba, whose history goes beyond Arabic to Roman times and beyond that to Phoenician, has enough monuments of the past to satisfy any chamber of commerce. Leisure-minded tourists may find more to interest them in the garden enclosures within

Cordoba's stately homes, green oases of indispensable refuge from the scorching heat that visits this part of Spain in summer.

Madrid

The highway from Cadiz to Madrid, the country's lifeline to its Atlantic naval bases, has lately been rebuilt into a superlative automobile road. We had little difficulty pushing the Simca a distance of 500 kilometers between breakfast and dinner, so far the record for a day's travel. Madrid, approached from the south across the mid-peninsular plateau, rises in the distance in flat profile from its level surroundings. On closer acquaintance Madrid proves a pleasant place, its personality of a relaxed sort compared to cities such as New York or Chicago. Although Madrid is quite proud of possessing the highest *rascacielos* in Europe, the prevailing dimension of the city's architecture is the horizontal. Except in the heart of the downtown section the buildings are low, abetting the sense of ease and spaciousness produced by wide tree-shaded boulevards and magnificent squares set with heroic sculptures and sumptuous fountains. . . . If the *Madriileños*, during our brief contact with them, appeared a shade less amply mannered than the people of Spain's country districts, the same can of course be said of metropolitan denizens in any land. The visitor may wonder that any manners have been left at all after the vicious fighting, Spaniard against Spaniard, of less than twenty years ago. During the Civil War the long battle for Madrid was carried on north of the city, on the heights that today support the vast, imposing campus of the University. A favorite project of the present powers of state, the University of Madrid has been endowed with a liberal rebuilding program and now lacks nothing but a few centuries of maturity to rank with Salamanca. . . . The four days allowed by our itinerary for Madrid and its peripheral attractions—Toledo, the Escorial, the still-walled city of Avila—were lamentably few. As much time might have been spent among the immense treasures of the Prado Museum alone, with its matchless collections of Goya, Murillo, Rubens

and dozens more of the old masters, including the incomparable Velasquez. In Madrid more than in most places the tourist is forced, willy-nilly, to "leave something for the next time."

San Sebastian

Every evening, Saturdays excepted, San Sebastian's fishing fleet sails off to the Bay of Biscay, its departure attended by a throng of wives, children, sweethearts and the merely curious. An hour before sailing time the crews make supper on board the open decks of their ships, each man filling his canteen from a boiling pot and taking a share of the wine bottle by turns. The meal's remnants disposed of overboard, engines are started, lines cast loose; one by one the boats, under power, clear the concrete arms of their protective basin, hoisting sail as they emerge into the harbor and disappear seaward. They return to harbor in early morning, if not to San Sebastian then to Bilbao or Santander, depending on weather conditions and where the fish happen to be feeding. Wherever the catch may be landed a trade union takes care of marketing it; or failing any catch at all, the union will take care of the fishermen and their families, temporarily at least. . . . More dependable fish, it seems, are the tourists who migrate to San Sebastian in large shoals each summer, including a part of the government moving north to escape Madrid's heat. The tourists' accommodations, at some distance from the quays and narrow streets of the fishermen's quarter, are represented by an endless profusion of small stodgy hotels, uniformly cheerless in aspect. Now, in early April, they stand empty for the most part, with the weather too chilly for any visitors except a few inquisitive petrels like ourselves. The tamarind trees, planted in long rows along the wide waterfront promenade, bear branches as empty as the sands of the beach. In a month or two the tamarind's purplish, orange-veined blossoms will garland all the seafront walks and the beach will come alive with bathers. Or so they say; but tourists have as little rest as fishermen, and tomorrow we must hoist sail aboard the Simca, setting our sights for France.

(To be continued)

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EDITORIALS

Are We Winning This Battle?

The present intense and widespread interest in cardiovascular disease began only a few years ago. Its growth has been phenomenal, and can be appreciated only by those who have observed it closely or who have worked actively to foster it. Those who have graduated from medical schools within the past few years, or who have developed an interest in this special field only recently, can scarcely comprehend what gigantic strides have been made in the past decade.

The extraordinary increase in the number of scientific investigators in this field has been due in part to growing awareness of the importance of cardiovascular diseases, and in part to the spectacular growth of the funds available for research. At present this support comes in large part from three sources: the Life Insurance Medical Research Fund, the American Heart Association, and the National Heart Institute, one of the National Institutes of Health of the U. S. Public Health Service. The first of these three historically was the Life Insurance Medical Research Fund. In a very real sense it blazed the trail which others have helped to extend into a broad highway.

The JOURNAL is fortunate in being able to present to its readers an informed and penetrating discussion of the recent additions to our knowledge of this group of lethal diseases, written by the first and only director of that Fund. Dr. Dieuaide was a logical choice for this position, entirely new and of crucial importance at the time the Fund was started, inas-

much as he had a broad background of experience in clinical medicine, teaching, research, and administration. It is most gratifying, and perhaps surprising also, to find that a busy administrator has retained a deep interest in the direction and results of investigations as well as in making funds available for their support. Dr. Dieuaide's admirable and deeply perceptive survey of an immense field is heartily commended to our readers.

Medicare Report

Major General Paul I. Robinson, executive director, Office for Dependent's Medical Care, gave a detailed report to the MEDICARE Advisory Committee on May 17. The report covered five months of experience with the program and these months have turned up a great number of problems, none of them unsurmountable according to General Robinson who is responsible for the operation of MEDICARE.

With complete candor, the report discussed charges made by some organized medical groups that MEDICARE is socialized medicine; acknowledged difficulties of preparing fee schedules; deprecated the continuing controversy involving hospitals and certain medical specialties over billings for services, and presented statistics on expenditures to date.

Up to May 7—exactly five months after the program's inception—the Robinson office had received 36,922 hospitalization claims for total of \$3,562,-297.25. Mutual of Omaha handled 19,667 and Blue

Cross 17,255. In same period there were 53,802 medical service claims for \$3,666,583.40. Hospital bills averaged \$96.48 and medical, \$68.15.

In 17 States where Mutual of Omaha is fiscal agent for hospitalization of dependents, the 19,667 billings came to an average daily cost of \$18.78. This compared with \$20.86 average for States and territories handled by Blue Cross. But General Robinson explained that costs run higher in Blue Cross territory (including Atlantic and Pacific Coast States), as shown by statistics of American Hospital Association.

Despite all pains taken when schedules of allowances for physicians' fees were being drawn up last year, bugs in these agreements remain numerous, General Robinson declared. This is due in large measure to varying definitions, among the various States, of postoperative care, cesarean section and other services. Anesthesiologists may have as many as four different methods of calculating their fees.

All agreements are due to expire on June 30. At Friday's meeting, the advisory council was asked to approve certain recommendations bearing on negotiation of new contracts. Objective: To straighten out as many kinks as possible.

The Robinson report also cites difficulties with physicians' claim form, about 50 per cent of which have to be returned to the doctor for one or more corrections . . . troubles in Rhode Island arising from the State Medical Society's informing members that they do not have to accept MEDICARE compensation as full payment for services to military dependents . . . complications resulting from law's provision for semi-private accommodations, when many smaller hospitals have private rooms only. Another sore point: Resentment by Army and Air Force dependents against program's denial of dental benefits, to which they were entitled previously.

Notwithstanding the many shortcomings, "we believe we now can present you with a program which is a workable one," General Robinson said to advisory group. "We believe also that the principles inherent in this program are possible of extension." He observed cautiously that "some provision should be made for dental care, although we have not congealed our thoughts at this time." (WRMS.)

It will be remembered that General Robinson presented his first public discussion of MEDICARE

before the Connecticut Clinical Congress in Hartford on December 6, 1956, the day before the program went into operation.

Aging and Its Challenge to Medicine

In this issue Dr. Bortz makes a welcome contribution to the problem of medical care for the aging population and suggests lines of research following through on some work now in progress.

He feels that the problem will be with us in some force because every day one thousand people are reaching age sixty-five and hence, in too many instances, are out of productive capacity. Then again since advances in medicine have increased longevity, it has at the same time made people live long enough to be susceptible to more illnesses than before. In this situation the physicians have need of greater knowledge of the process of aging and cell rehabilitation correlated with more advanced knowledge of physiology.

For this care he feels that the generalist is in the most strategic position to understand the total individual. The specialists and researchers must garner the knowledge for him to use.

Care of the aging includes a broad knowledge of practical biology, physiology, clinical medicine, as well as the sociological and psychological problems that beset this group. Medical societies have wholeheartedly joined in the attack. The need of this is obvious in the changing mortality trends in the past half century toward the degenerative diseases, such as arteriosclerosis, with its heart and brain components, nephritis, diabetes and degenerative pulmonary disease, and cancer.

Dr. Bortz believes that from a physiological point of view, hereditary endowment, protein starvation and defective tissue oxygenation, particularly through lack of exercise, may be considered among the traumatic causes of aging, but that the accumulation of many lesser traumata, such as tobacco, alcohol, dietary habits and illness may also contribute. He also stresses the need for properly balanced body fluids and metabolites. Perhaps as he sees it in senile individuals many changes develop as part of malnutrition, or what we might term (to coin a word) dysnutrition, as applying focal symptoms with every organ in the body affected.

In Dr. Bortz's opinion, the challenge against atrophic changes and toward cell renewal in the human body is now at the door of medicine and its

solution promises many social rewards. One gets his implied warning also that the job requires the co-operation of all segments of society. While he is pleased with the accomplishments he is not totally satisfied that enough of the answers are yet in. When advanced research on body fluids, protein cell content, and the relationship of arteriosclerosis to serum lipoproteins are developed, he is optimistic that the span of life may be advanced by probably a quarter of a century.

Dr. Bortz's understanding of the social and political features, combined with the industrial and medical factors, offers the researchers in all categories something to aim at for the well-being of our Senior League members of society.

The Problems of Retirement

With the lapse of time the problems of retirement, which sooner or later face every worker, have become increasingly complex. This is mainly due to two factors: (1) that modern medicine, preventive and curative, has resulted in a considerable prolongation of the average length of life, and (2) that those controlling many occupations have set up arbitrary retiring ages. Now about thirty years longer than it was in the nineteenth century, the average duration of life has, roughly speaking, reached the biblical "three score years and ten." Many infections which formerly killed mainly children have been wiped out, and some which attack people of all ages, such as tuberculosis, while not yet completely conquered, are so greatly reduced in number that sanatoria for tuberculosis are being abandoned or used for patients with other chronic diseases. The end of polio is in sight and the leading causes of death, aside from accidents, are diseases of the circulatory and nervous systems and cancer, using the latter term in its broadest sense.

As Donald F. McClure has recently pointed out,* there are three interrelated basic facets to the retirement problem: finance, health, and mental adjustment. The satisfactory solution of these problems demands that young workers of all types become more generally and acutely aware of their importance so that they may take adequate steps early in their careers to meet them satisfactorily.

It is, of course, well known that several methods of providing financial sufficiency after retirement have already been put into effect. The Government

covers many classes of workers with its social security program which is sometimes based on equal contributions from employers and employees and sometimes covered solely by employers. Many insurance companies offer a variety of methods for accumulating presumably adequate incomes after retirement and a fair number of business corporations advise their employees on methods for financing the retirement period. Most colleges and universities have fixed retiring ages and definite retiring allowances. The difficulty with these plans lies not necessarily in their nature but in the frequent unawareness of their future beneficiaries that certain steps to insure a financial and socially adequate period of retirement must be taken years ahead of the retirement age. No one, of course, can foresee periods of inflation in which the buying capacity of the retiring allowance may shrink 50 per cent or more.

The question of the health of those who retire is of vital import, especially because of its influence on hobbies, the acquisition of which is essential to the contentment of retired people. As Dr. George Whipple has pointed out, there are an enormous number of possible hobbies ranging from the strictly intellectual to the strictly physical. Obviously some handicapped retired people cannot indulge in hobbies which would be beneficial if they were physically and mentally fit. As Mr. McClure states, it is psychologically important that the retiring individual should have the feeling that he is "retiring to" something rather than "from something." The importance of an annual physical check-up should be pointed out to young workers.

Dr. Walter Alvarez has pointed out in one of his newspaper articles that some old people are apt to change their residence on retirement too hurriedly, forgetting that the factor of mental adjustment is an important one and that they may be much happier with old friends in the neighborhood where they were active than in a strange place, especially if they are not good mixers. No two people are exactly alike in their capacities and this must be taken into account in plans for retirement.

G. B

*Panel meeting on the problems of retirement, Henry N. Pratt, moderator; Edward B. Allen, George E. Johnson, Donald F. McClure and Allen O. Whipple, panel members. Bull. New York Acad. of Medicine, 1957, Vol. 33, No. 1, p. 40.

A New Look at Medical Care Costs

Having a baby is not only much safer for mother and child today than it was 25 years ago, but measured in comparable dollars, its medical and hospital care costs are about 18 per cent lower.

This fact is as welcome as it is startling, for maternity care is a significant part of all medical care—about 17 per cent of all admissions to our hospitals in 1953, for example, were maternity patients. The average hospital stay of obstetric patients has been reduced from 12 days to 5, but even at a higher cost per day of hospital care, the average hospitalized patient is paying less for hospital care than in 1930—\$92 as contrasted with approximately \$102 (comparable dollars), a reduction of about 10 per cent; moreover, special nursing care in the hospital is now almost never necessary, and this means added savings.

It is true that physician fees for maternity care, measured in comparable dollars, have increased somewhat in the 25 year period; but this increase is small in view of the greater proportion of physician time devoted to prenatal care and the increasing proportion of total care being given by specialists in obstetrics. The figures certainly tend to refute the criticism that physicians' unit fees have greatly increased as a result of the growth of voluntary health insurance. About 33 per cent of all obstetrical patients have some part of the physicians' fees paid by insurance.

But lower maternity care costs means much more than dollars saved for the young family. They are also a reflection of our whole medical care economy, and they provide a new opportunity for examining criticism of the costs of medical care.

Since 1930, advances in medicine—perhaps most dramatically illustrated in drug discoveries—have lengthened life, have extended the number of years over which the average person needs medical care and have introduced many new medical and hospital procedures that require costly equipment and highly trained personnel. This progress has changed public attitudes toward medical care. Americans use health services far more frequently than in the past, and have developed concern about the necessary personal expenditures.

Voluntary health insurance has grown phenomenally as a result of this concern and of an awareness that family medical costs are not evenly distributed—that in any given year some families have very high medical costs while others have minimal expenses. Approximately 70 per cent of the public has therefore invested in health insurance protection.

Progress in health insurance protection, however, has not allayed all public criticism that medical costs, like the costs of other necessities, are perhaps higher than they should be. Yet there is little basis for such criticism; the facts speak for themselves.

Americans have consistently spent about the same proportion of their expendable incomes—4 to 5 per cent—for medical care in the past 25 years. Yet a broader range of diagnostic and treatment facilities is now available to many more people than ever before. Maternity care and the treatment of many illnesses is much less expensive today; hospital stays are shorter; time spent away from family and work has been greatly reduced.

This does not mean that unit medical costs or total expenditures for medical care are due to decline. But it seems incredible that with greater knowledge, greater safety for patients and a wider range of services, the cost of any medical service such as maternity care can be as low as it is. With increased public awareness of the real facts, it is likely that Americans could more nearly reach the full potential use of all health services.

Erythropoietin, a New Hormone

A research train at the University of Chicago has reported the discovery of a new hormone, erythropoietin, that controls red blood cell formation analogous to the mechanism by which the level of blood sugar regulates the production of insulin. This new hormone is produced in response to the changing balance between the oxygen demand and supply of the body.

Erythropoietin is produced by the kidneys and is found in normal blood of human beings and animals. It stimulates the bone marrow to make the red cells. Though it has not been chemically isolated, it has been concentrated in blood serum by 100 to 1,000 times its normal amount.

PROGRESS IN CLINICAL MEDICINE

OUR ADVANCING KNOWLEDGE OF THE MAJOR CARDIOVASCULAR DISEASES

FRANCIS R. DIEUAIDE, M.D., *New York, N. Y.*

The Author. *Scientific Director, Life Insurance Medical Research Fund*

SUMMARY

The possible etiological factors of atherosclerosis are discussed, whether a disturbance in fat metabolism or due to any one of many other external or environmental factors or to heredity. The causes of atherosclerosis are complex.

Basic biochemical research is now in progress, aided by the Life Insurance Medical Research Fund. One of the new discoveries has shown that a complex pattern of hormonal activity may control cholesterol synthesis and thus have a bearing on atherosclerosis. Research on the transportation of lipids in the blood is yielding new information.

The causes of essential hypertension still remain to be discovered. The various numerical substances capable of raising blood pressure are discussed. Impaired retinal vascular reactivity shows up in hypertensive patients before any chemical evidence of impaired kidney function. Heredity is also an important factor. Definite improvement in the treatment of atherosclerosis now exists.

Experimental animals have been shown to develop rheumatic heart disease following streptococcal throat infections. Progress in reparative surgery of heart disease has developed rapidly.

It should be noted in passing that the old idea of arteriosclerosis as merely an essential feature of old age is no longer held.

Atherosclerosis has been produced in many experimental animals by a variety of procedures all of which cause disturbances in lipid metabolism. The resulting disease cannot be separated from human atherosclerosis. The difficulty here is twofold: first, we cannot be sure these animals resemble man in

It is only during the past decade that concerted efforts have been made to solve the major problems of heart disease. In these ten years, atherosclerosis and hypertensive disease have become the major interests of many highly qualified investigators. Much pertinent work is being done in the basic medical sciences, as well as by clinical and epidemiological methods. A large store of knowledge has been accumulated—much of which need not be related here. We should bear in mind, however, that parts of this hard-won information, now seemingly unimportant or even not pertinent to the central problem, may yet turn out to be key points in the final explanation of atherosclerosis or hypertension.

The aim of this presentation is a brief description of outstanding recent results, with some evaluation of their apparent significance and indication of the work that now appears to be most urgently needed.

ATHEROSCLEROSIS

Atherosclerosis, largely because of resultant coronary heart disease, is easily our most serious form of cardiovascular disease. It is present in most adults and it causes some 40 per cent of all deaths. According to the theory now held by most students of atherosclerosis, the disease is mainly the result of a disturbance in fat nutrition or fat metabolism, especially involving the accumulation of cholesterol in arterial walls.

The evidence for this theory is weighty, but not yet conclusive. There are critics who doubt its validity, believing the fat disturbances to be secondary to some unknown pathological process. Various efforts now made to put particular consequences of the theory into practice rest on slender foundations. Nevertheless, the general hypothesis, whatever its fate may be, has been and assuredly will continue to be the basis of much productive and valuable work.

their reaction; and second, we do not understand how these distinctly different procedures work.

In the effort to explain cholesterol accumulation in atherosclerosis, one must consider whether dietary composition is a fundamental factor. The commonest method of inducing atherosclerosis in animals is to feed them more or less large amounts of cholesterol, either alone or with some other procedure. It has been shown, however, that plasma cholesterol levels are influenced by dietary fat content, rather than the cholesterol content as such. Furthermore, fats of vegetable origin are influential as well as those of animal origin. When blood fat is raised by feeding neutral fat, hypercholesterolemia quickly follows. Work is now being done to test the possibility that the chemical structure (degree of saturation) of dietary fat is more important than its animal or plant origin.

On the basis of epidemiological studies, Keys and others have presented a persuasive case for the theory that atherosclerosis is the result of a high fat diet. It is notably true that the prevalent American diet has come in the past generation to contain a very high proportion of fat (up to 40 per cent or more of total calories), and that our plasma cholesterol levels are high compared to those of many peoples apparently consuming much less fat and much more carbohydrate. The incidence of coronary heart disease is described as much lower among various peoples whose fat consumption is relatively low. The evidence is not yet entirely convincing, because of doubts as to the accuracy of the diagnosis and of the applicability of the estimates of the dietary composition among the peoples involved. Other variables than dietary fat may be factors.

Further work on these lines may be expected to make more precise information available. In addition, data are needed as to the role of total caloric intake and the interrelationships of various dietary nutrients.

The important suggestion has been made that physical activity may play a key role in atherosclerosis. This might be either through an effect of activity itself on bodily functions (such as endocrine function) or through the interrelation of activity and diet. Evidence has been obtained indicating that high fat diets do not increase the level of serum lipids as long as the excess energy is dissipated as exercise. On the other hand, serum lipid levels apparently tend to rise when fat is deposited as the result of inactivity while on a high fat diet. Here again,

skepticism is expressed by some workers as to the significance of exercise. It is obviously another important matter on which our information is deficient.

Whether obesity is or is not associated with the development of atherosclerosis is not clear. An answer to the question cannot easily be obtained. One difficulty is that the disease may develop over a period of many years, whereas obesity may not continue to be present. Life insurance statistics indicating the absence of obesity in coronary victims may be misleading.

Many other external or environmental factors have been suggested as playing parts in the development of atherosclerosis, such as "stress." Although the causation of the disease may well be complex, no significant support now exists for any of these other influences.

There are slender indications that heredity may determine a tendency to atherosclerosis. It should be clear, however, that the reported rarity of the disease in certain peoples, such as the Chinese, is not evidence that a genetic factor is at work, as there are too many other possibilities that have not been excluded. The very prevalence of atherosclerosis in our population of heterogeneous origins would seem to speak against a serious role for heredity.

A thought-provoking study of geographic patterns in coronary heart disease mortality has recently been reported by workers of the U. S. Public Health Service. The results show that the death rates for coronary heart disease in 1950 were about twice as high in some States as in others. For example, the rate per 100,000 for white males in New York was 394, against 191 for New Mexico—a difference of over 100 per cent. There are many peculiarities in the rates. That for Nevada was 333 (174 per cent of the New Mexico rate). Even between New York and Illinois (rate 293) there was a difference of 34 per cent, which is particularly difficult to explain. The rates for white females vary in substantially parallel fashion.

One immediately thinks, as did the authors of this work, of the possibility that differences in diagnostic standards may be chiefly responsible for the varying rates. There are, however, several internal evidences in the results that this is not the case, although diagnostic habits probably play some role.

The authors tested the possibility that urbanization is responsible for the high rates. They found

no indication that the pattern for rural areas differs much from that for the country as a whole.

Incidentally, this study showed that coronary heart disease in 1950 caused 20 per cent of all deaths of white males aged 35 to 44, and from then on about one third of all deaths. For the adult years, coronary heart disease death rates are reflected in the rates for all causes.

The results of this study are a new indication of the complexity of the problem of what causes atherosclerosis. No simple interpretation can now be offered in terms of any current theory. Yet these results suggest a number of studies that might be fruitful if they are done by intensive methods providing precise information.

As is well known, middle aged women are only about half as susceptible to atherosclerosis as middle aged man. Little new light has recently been thrown on this important sex variation. The situation illustrates our lack of knowledge. It was recently remarked in a medical editorial that differences in dietary patterns can hardly account for this sex variation, as significant dietary differences apparently do not exist. Yet they may exist. Casual observation of female forms in fact seems to suggest that a substantial fraction of younger and middle aged women have more conservative dietary habits than men.

Let us turn now to a brief consideration of some recent fundamental biochemical work bearing on atherosclerosis. It is clearly desirable to acquire an understanding of the abnormalities in bodily mechanisms which give rise to the disease and it may be that knowledge of these abnormal mechanisms is essential for the development of methods of controlling the disease. Partly because our scientific advisors believe such basic biochemical research is the best means of attack and partly because other support is less readily available for such work, the Life Insurance Medical Research Fund has aided many programs of basic biochemical research. Many important results have been accumulated, some of which may be helpful in other directions, such as the cancer problem, as well as for atherosclerosis. Many of these programs deal with the metabolism of cholesterol, other lipids, and lipoproteins.

It is notable that our knowledge of fat metabolism is relatively poor, especially as to what lipids may be essential and as to the interrelations in nutrition between various lipids and between them and other nutrients.

Biochemists interested in this field are impressed by the amount of cholesterol synthesized in the body which ordinarily greatly exceeds the amount taken in as food. It has also been established that the blood cholesterol content may rise or fall independently of the dietary intake. The body's synthesis of cholesterol is a process of major importance. The main pathways and key intermediary substances have now been described. Some of the new intermediates, such as squalene, are now recognized for the first time as important biological compounds. This work has now progressed so that it is possible to study the enzymatic mechanisms in cholesterol synthesis. It may soon be possible to analyze the factors which control the supply of cholesterol.

Indications have already been secured that a complex pattern of hormonal activity may control cholesterol synthesis. In these findings, as well as in other ways, leads have been obtained that might result in means to control atherosclerosis.

Helpful new information has been gained about the transportation of lipids in the blood. This occurs in complicated patterns involving differing physical states for the lipids and differing compounds with proteins (lipoproteins). The patterns have been shown to vary, both in normal subjects and in patients. The reasons for such variations, and especially their relations to diets, are matters of urgent interest. So far, the prevalent feeling is that these patterns cannot be reliably used in diagnosis or prognosis.

As to total quantity, cholesterol synthesis occurs mainly in the liver. It is notable, however, that the arterial wall has been found capable of making cholesterol. Indeed, most of the phospholipid in the atherosclerotic aorta is synthesized *in situ*. It is remarkable that while cholesterol feeding depresses cholesterol synthesis in the liver, it does not do so in the arterial wall. This might account for continuation of the sclerotic process after the initial factor ceases to operate.

These findings and other considerations remind us that the arterial wall should not be regarded as merely passive. Some explanation is needed for the extremely patchy distribution of atherosclerosis. Recent work has given renewed interest to the possible role of repeated arterial injuries, such as those caused by various infections.

It has been clearly demonstrated that regression of atherosclerosis can be produced, though direct evidence in man is lacking. A recent report describes

gross regression in animals treated with the heparin-like substance, sulfonated alginic acid. Regression occurred in spite of continued high cholesterol feeding.

Since the significant damage resulting from atherosclerosis is due to thrombosis, we need to know more about the initiation of this process. Little new information is available, however. It is probable that small coronary occlusions are much more common than we realize. In a recent carefully studied series of autopsied cases of occlusion, 87 per cent of the cases showed more than one vessel to be severely obstructed. The development of anastomoses is saving many lives.

One of our worst handicaps is our inability to diagnose the vast majority of cases of "silent" atherosclerosis. This is a handicap not only in handling practical human problems, but also in investigative work.

In regard to the treatment or prevention of atherosclerosis at present, I can only state my personal opinions, since there is no general agreement as to what should be done, if anything. The theory that atherosclerosis is linked to a disturbance of fat metabolism is the most promising one we have. The information that many Americans are now consuming relatively large amounts of fat is impressive. Available evidence, however, falls far short of justifying a general campaign for a dramatic change in our dietary habits. I would limit general advice to the avoidance of overweight, the maintenance of significant physical activity, and restriction of dietary fat to a reasonable proportion. Any stricter dietary management should be suited to the individual by his personal physician.

I believe we have ample justification for looking forward to effective means of controlling atherosclerosis.

ESSENTIAL HYPERTENSION

Essential hypertension is a diagnosis reached by exclusion. The majority of the causes for secondary hypertension lie in disturbances of kidney, adrenal, or central nervous system functions. We are still quite in the dark as to the cause of essential hypertension, although the work of recent years has clarified the problem somewhat. The usual current explanation of the etiology is a mosaic statement, attempting to bring in all or most of the factors believed to play some role in high blood pressure.

A view long quietly held by some has recently

been brought to the fore, according to which hypertension is not in itself a disease. This view, however, seems merely to emphasize the fact that many hypertensive individuals live long years without symptoms. It is also true that the height of the blood pressure is not necessarily a measure of the severity of complications. High blood pressure appears to be merely a manifestation of a more general and deepseated disturbance, the nature of which we particularly need to know. Barring accidents, most hypertensive subjects undergo serious pathological changes related to their hypertension. In a recent careful study, although some individuals were found to live with hypertension as long as forty years, the average age at death was only fifty two.

A continually active line of work deals with humoral substances capable of raising the blood pressure. The more important of these at present are angiotonin (hypertensin), pharentasin, and the adrenal hormone nor-adrenaline. Aldosterone, the relatively newly isolated adrenocortical hormone, has been added to this group through the recent finding that hypertension patients excrete comparatively large amounts of it. Minute amounts of aldosterone cause retention in the body of sodium and promote excretion of potassium. Since these reciprocal disturbances in mineral metabolism are features of hypertension, confirmation of this new finding is especially desirable.

Extensive studies have been made of the mechanism by which dietary deprivation of potassium causes a fall in blood pressure. It was found to be linked with adrenocortical function.

It is a common assumption that kidney damage plays a part in the pathogenesis of hypertension. We know to our regret that evidence of kidney damage cannot be found by present methods in many hypertensive subjects. The usual view is that in the presence of kidney damage, a blood pressure-raising agent is produced. Yet one of the striking findings in recent years is that hypertension can continue in dogs from which the kidneys have been removed.

A hitherto unrecognized pressor factor has been found in normal human urine, as well as that of other animals. Its excretion is dependent upon adequate protein nutrition, adequate adrenocortical function, and adequate kidney function. The behavior of this agent suggests that renal hypertension may be the result of failure to excrete it. Purification of this agent, now under way, will make further studies possible of this interesting discovery.

Hypertensive patients have recently been shown to have impaired retinal vascular reactivity in advance of clinical evidence of impaired kidney function. An objective method has thus been provided for assessing degenerative vascular changes and relating them to renal function. By the time renal damage is apparent, loss of retinal vascular reactivity is usually far advanced. This finding is a new indication that generalized degeneration occurs relatively early in the small arteries of hypertensive subjects.

New information has strengthened the long-standing impression that heredity is a weighty factor in the tendency to high blood pressure. The fact that no method is apparent by which we could influence a hereditary factor encourages the search for other causes.

I am conscious that this is a highly selective, even somewhat sketchy, account of recent work bearing on the pathogenesis of hypertension. In particular, the significance of pharmacologic studies of newer hypotensive agents has been omitted.

In regard to treatment, recent reports show that there has been considerable improvement in the management of hypertensive patients. Patients with slight disturbances are more conscientiously and more successfully handled with reassurance, appropriate psychotherapy, and mild sedation. Rauwolfia and its preparations have been found very useful. More severe cases are often treated with rauwolfia in combination with veratrum (as protoveratrine).

The most striking advance, however, is in the ability to prolong the lives of patients in the malignant stage by the use of the methonium compounds and hydralazine, and even by diet alone. A recent report describes twenty seven out of forty six patients with malignant hypertension and moderate nitrogen retention as alive and working after almost two years. It is stated that heart failure almost disappeared as a cause of death in patients treated with ganglionic blocking agents and hydralazine. Coronary occlusion became the outstanding offender.

Dietary management, with restriction of total caloric intake and of sodium content, has been conclusively shown to be effective in controlling the progress of many even severely affected patients. I have the impression that much more could be made of dietary management, especially in cases in which sodium restriction does not have to be as great as it is in the rice diet. The difficulty of the securing of

the long-term, careful cooperation of patients should be overcome.

The successful use of the powerful antihypertensive drugs now available and of very low sodium diets calls for a high degree of skill. Although a few students believe that basic aspects of the disease are affected by these treatments, it seems best to regard them as palliative. Certainly we have no way at present of preventing the development of essential hypertension.

RHEUMATIC HEART DISEASE

The outstanding recent development in connection with rheumatic heart disease is the reliable production of the condition in animals, following streptococcal infections of the throat. Practically all the experimental animals develop heart damage like that of human rheumatic heart disease. Previous efforts to this end have been successful in only rare instances. It is of special interest that the early results do not support the prevalent theory that an immunological mechanism underlies rheumatic fever.

Reference should be made to the successful prevention of rheumatic fever by the prophylactic use of penicillin and sulfonamides, although this is not solely a recent achievement.

The surgical relief of mitral stenosis has become a relatively common procedure. In many of the properly selected cases, very good results are obtained. It is now realized, however, that only patients with predominant valvular obstruction should be selected for the operation. Those with predominant myocardial damage are not benefited. Thorough physiological study has been shown to be necessary, in addition to clinical study.

SURGICAL TREATMENT

Great progress has been made in the development of reparative surgery in the open heart under direct vision. On the basis of experience gained with human cross-circulation donors, much simpler and more satisfying procedures have been developed by the workers at the University of Minnesota. A simple disposable plastic tube is used to act for the patient's lungs in oxygenating blood and removing carbon dioxide. An efficient pump replaces the patient's heart during the operation. Patients with congenital heart malformations hitherto inaccessible have already been successfully treated. The indications are that a large number of infants with congenital heart

defects may be cured. Furthermore such procedures may make it possible to extend greatly the scope of surgical treatment for acquired forms of heart disease. The appearance of fibrillation of the heart muscle during these operations has been one of the dangers faced by the cardiac surgeon. The recent development of antifibrillatory drugs is very helpful.

I believe you will agree with me that substantial progress has been made in heart research and that the outlook is most encouraging.

Blue Shield and the Medical Society

Every doctor has a personal responsibility for the success of his Blue Shield Plan, and a direct opportunity to take part in its control. For the first, basic requisite of any nonprofit prepayment plan that wants to use the name and symbol "Blue Shield," is that the plan be formally and continuously approved by the state and county medical societies in its area of operation.

Another requirement, no less basic, is that a Blue Shield Plan's medical policies and schedules of payment be determined by physicians.

Blue Shield is in fact our own chosen mechanism for making our services more readily available, through prepayment, to our patients.

As such, one would expect the relations between all Blue Shield Plans and their sponsoring medical societies to be as intimate and understanding as between the members of any well run family.

A recent survey conducted jointly by the Public Relations Department of AMA and the Professional Relations staff of Blue Shield Medical Care Plans indicates that relationships between the Plans and their local medical societies in general are excellent, and they have improved most notably in the last few years.

Similar questionnaires sent simultaneously to the Plans and medical societies brought prompt responses from 75 per cent of the Plans and 78 per cent of the societies. Of these respondents, 94 per cent of the Plans and 89 per cent of the medical societies reported good or excellent relations with one another. The interesting fact that in three cases the Plans thought their relations with the medical society were excellent while the society reported them to be poor, and in three other cases the contrasting opinions were reversed, only proves that we are dealing with people.

When this questionnaire probed a little deeper into the specific character and methods of liaison, however, it revealed some sizable areas of weakness and some attractive opportunities for improvement.

For example, only 51 per cent of the responding Plans and 58 per cent of the medical societies reported that they maintain "a specific liaison committee" between them. That some of these committees have not exactly rendered conspicuous service is suggested by the fact that in six cases the Plan and the medical society disagreed as to the very existence of a liaison committee between them. As might be expected, there was a very strong correlation between the areas where liaison committees are operating and the areas where the mutual relations are of the best.

Other specific questions related to jointly sponsored meetings for doctors' office assistants: the inclusion of Blue Shield information in the medical society's orientation program for new members; the setting up of cooperative mechanisms for the use of medical society mediation committees to handle patient complaints; and jointly sponsored indoctrination programs for medical students, interns and residents. In each of these areas of potential cooperation, a majority or a very sizable minority of the respondents reported no action as yet.

If the American doctor needs Blue Shield, it is equally true—if not more so—that Blue Shield needs the American doctor. Without his guidance, Blue Shield might become something quite different from what the profession wants it to be. Without the doctor's support and active participation, there would not even be a Blue Shield.

Advertising With a Modern Twist

The Scharringhausen Pharmacy in suburban Park Ridge can turn out advertising copy that "sings." For instance, a recent ad in the Park Ridge Herald read: "Tranquilizer! No Prescription Needed! May be Habit Forming! Recommended by Many Physicians! Not For Sale—It's Free!"

"Those statements may sound contradictory but they're all true, for the 'Peace of God That Passeth All Understanding' is indeed a tranquilizer of recognized merit."

Then the advertisement urged readers to attend the "church of your choice" during the Lenten season.

THE PRESIDENT'S PAGE

THE House Interstate and Foreign Commerce committee recently released the result of a staff study on the financial and other problems of medical schools. This 479 page report, based on questionnaires sent to medical and other scientific schools, is not an official committee report, but is expected to serve as a background for the hearings on the administration's bill for U. S. construction aid to medical, dental, and osteopathic schools.

All but a few of the 83 schools which replied said they would apply for grant if Federal aid were authorized. Their construction projects would cost four hundred million dollars of which 60 per cent would be chargeable to teaching and 40 per cent to research. About 70 per cent would be spent for new facilities, 20 per cent for expansion, and 10 per cent for rehabilitation. All six osteopathic schools, and ten of the eleven schools of public health said they also would apply for Federal money.

There were about fifteen thousand applications for administration to medical schools in the 1955-1956 academic year of which about a half were accepted, filling the freshman classes to capacity, and a sharp increase in the number of applications is expected in the next ten years. The report quotes the Association of Medical Colleges as stating "that while some existing schools with enlarged facilities might be able to accept additional students, increased capacity for the training of medical students must be brought about primarily by the establishment of new schools. In the absence of additional capacity, even beyond the expansion now underway, a substantially lower percentage of applicants is likely to gain administration to medical schools.

While medical schools show a wide variation in teaching costs, from one to fifteen thousand dollars, tuition income covers a smaller and smaller percentage of total operating expenses. In 1956-1957 it averaged only 18 per cent. In the same period states contributed about fifty-two million dollars for the operation of forty-seven medical schools compared to a total expenditure for all medical schools of one hundred and eleven million dollars. Thirteen States and the District of Columbia with a total civilian population of more than nineteen million did not contribute any public funds.

W. Bradford Walker, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN

Telephones: UN 5-0587, LO 2-0836

SECRETARY'S REPORT

Mr. Speaker and members of the House of Delegates. The President, Chairman of the Council and Treasurer of the Society, have reported to you this morning and there are reports of all of the Society's committees published in the agenda which you have before you. There is also a membership report from the Secretary on page 11. With all of this information it may appear somewhat unnecessary for the Secretary to go further, however, there are certain details of the operation and administration of the Society that are not contained in other reports and I believe you will be interested in having them briefly presented.

1. The Dependents Medical Care Program authorized by Public Law 569 went into operation on December 7, 1956. It is probably the most unique project in which the Society has ever engaged and in the formative period presented problems that we had never before experienced. However, with the understanding guidance of the MEDICARE group in the Surgeon General's Office of the Army and unfailing cooperation from Connecticut Medical Service it has developed with a minimum of confusion. The operation is in the nature of a no-profit-no-loss tripartite contract between the Society, the Department of Defense and Connecticut Medical Service. We all understand that there are points in it that need to be smoothed out and consideration of them is already in progress. Our latest request is to help to devise a new claim form that will not confuse medical and hospital care in the same document and perhaps provide a special form for reporting maternity cases since they are by far the bulk of the business done. Certain fee adjustments and additions are indicated and these we feel can be accomplished in time. To date 671 claims have been paid in the amount of \$38,000.

2. There have been changes in committee operations that should be brought to your attention. The long standing Committee on Emergency Medical Service has been discontinued as noted on page 28 of the agenda at the request of the Committee itself. Its original functions seemed to have moved away from it and from its personnel. The Council will in the near future give detailed consideration to the part the Society should take in state planning for civil defense and civilian disaster.

3. The new Committee on Accident Prevention, first proposed by Dr. Stringfield in a presidential address, has gotten off to a good start under the chairmanship of Dr. Speker. The area of usefulness of such committees is unlimited and many medical organizations are seeing the necessity for organizing them.

4. The Committee on Eye Care is also new and its activities during the first months of its operation have been so productive under the chairmanship of Clement C. Clarke that one wonders how the Society has gotten along all these years without a committee in this field. The work the Committee did in the discussion of legislation relating to the practice of optometry, now pending before the General Assembly, was an invaluable public service.

5. The addition to the building referred to by Dr. Fincke is a very useful asset to the Society and our thanks should go to Dr. Marvin for including in his presidential address the proposal that this addition be built and to Dr. Carl Johnson for directing the campaign for funds and supervising the planning. Dr. Weld and I are appreciative of your thoughtfulness in dedicating the fine large conference room to us.

* * * *

There are some operational procedures with which you may not be entirely familiar that are important in the Society's program.

(a) The State Advisory Committee to Selective Service is a part of the administration of the doctor's draft law that was created in 1950 and has probably been all but forgotten. It has been in so-called "temporary" operation for six years in the Society office and under the direction of the Secretary. It is likely now that the law, which will expire on June 30 of this year, may not be renewed and the office will be closed. Working personnel in the office has been supplied by the Selective Service and rent for space occupied has been paid by the Federal Government. With this office moving out we will have an opportunity to rearrange the space it occupies to advantage. What Selective Service will do to determine the availability of physicians and dentists when the Advisory Committee ceases to operate, has not been stated.

(b) The Connecticut Medical Examining Board which is another agency closely related to the Society, has experienced a great increase in its activities during the past two or three years. Most of this added load comes from the increase of foreign trained physicians seeking to practice in this country. Currently the Board handles more than 1,500 inquiries a year and well over half of these are from graduates of foreign medical schools, each of which presents a different problem. The space occupied by this Board in the Society's building and paid for by the State of Connecticut was doubled during 1956 and the Board's State budget for the next biennium includes provision for an additional clerk-stenographer. It is obvious that the opera-

tion of this Board will continue to take more time and personnel. The close relationship of the Board to the State Medical Society is unique in Connecticut.

(c) The Physicians Placement Service operated by the Society in cooperation with the Medical Examining Board is a quietly useful agency. The number of inquiries received from physicians seeking location in Connecticut has decreased for reasons unknown to me and in a sense the need for physicians in our State has also decreased. However, the demand for general practitioners in Connecticut is still unmet and there are always many vacancies in public and other full time employment. There are also localities where pediatricians, obstetricians and a few other specialists are needed. However, the placement service rarely receives inquiries from physicians seeking places for general practice, full time employment, pediatrics, obstetrics, or otolaryngology, so there is still something to be done. By far most of the applicants are general surgeons and physicians trained in internal medicine. The number of inquiries handled is about 500 per year.

(d) The Cornell Automotive Crash Injury Project is now in its third year and the medical phases of the program are operated in the State Society office. The administration of it has become so thoroughly systemized with the cooperation of the Connecticut State Police that it does not take much time and it has been a most interesting experience to which the physicians of Connecticut have contributed many valuable observations that have aided automobile makers in developing safety features in automotive design. Several publications and at least one film have been produced relying in part on our data. It is not known when the project will terminate.

(e) The collection of dues for the American Medical Association continues to be a complicating factor in the administration of the Society's office. It has been my feeling that it should have been improved and clarified before now by action of the American Medical Association but that has not been the case. The Society collects these AMA dues at financial loss which is shown, by estimate, in the auditor's statement on page 33, the amount of \$615.85 paid by the AMA is at the bottom of the Income and Surplus Statement in the left hand column and the actual out-of-pocket costs of \$945.65 is shown at the bottom of the right hand column. This last figure does not reflect the amount of clerical time that is spent on this activity. There are some methods that might be used to improve this situation and I am hopeful they will be given consideration during the coming year.

(f) Through the years of our operation personnel problems have been well answered. There are occasional changes which must be expected, but under Mrs. Lindquist's fine guidance and long experience we adjust to those changes with a minimum of difficulty. There are some periods during the year when we are understaffed but there is always a willingness to meet those extra demands and I commend the loyalty and efficiency of those who work for us, it is a good team. Perhaps in the foreseeable future it will be necessary to have more help but we will face that practically when it is definitely required. We are continuously called upon to do new things and are always willing to undertake them.

(g) The members of the Society are accepting growing responsibilities in the affairs of the American Medical Association. That Association will gravely miss the efforts, skill and statesmanship that Tom Murdock gave for so many years, his place will be hard to fill. But, others of our members are making significant contributions, Norman Gardner continues as a leader on the Council of the Rural Medical Service, John Gallivan on the Council of Industrial Health, Tom Danaher is an important member of the busy Council on Medical Service and Olan Meeker has recently become the regional member of the AMA Committee on National Legislation. Others are doing their part in related agencies, John Booth in the Federation of Medical Examining Boards of the United States, Bill Horton is a member of the Board of Directors of the Blue Shield Commission, and your Secretary continues as a member of the Executive Committee on the National Board of Medical Examiners. These are but a few things our colleagues are doing for medicine away from home.

Finally, I wish to pay tribute to the cooperation and understanding that I have at all times received from the officers of the Society and the members of the Council, and particularly I wish to note the ready assistance that I received from the Chairman of the Council, Dr. Fincke, and the President, Dr. Ogden. Dr. Danaher should also receive special commendation for his efforts in the exacting ground work that had to be done for MEDICARE. It was through his calm good judgment, both here and in Washington, that this unusual new project got off to a successful start. My compliments go also to the members of the Program Committee and the Hartford County Committee on Arrangements who have planned this meeting for you.

Creighton Barker, M.D.

Annual Meeting of the Council

The Annual Meeting of the Council was held at 160 St. Ronan Street, New Haven, on Thursday, May 9, 1957. The meeting was called to order by the President, Dr. W. Bradford Walker, at 3:00 in the afternoon. There were present Drs. Russell, Johnson, Barker, Weld, Danaher, Gallivan, Gibson, Clarke, Ursone, Buckley, Otis, Archambault, Schiavetti, Gens, Seigle, Meyers, Gardner, Dwyer, Gilman. Absent were Drs. Feeney, Fincke, Ottenheimer, Starr, Thayer.

Dr. Walker asked for nominations for Chairman of the Council for the year 1957-1958. It had been announced in the call for the meeting that Dr. C. Louis Fincke, former Chairman, did not wish to be renominated. Dr. Ogden nominated Dr. John N. Gallivan to be Chairman and this was seconded by several and the secretary was directed to cast a unanimous ballot for Dr. Gallivan.

After election Dr. Gallivan assumed the chair and introduced new members and changes on the Council as follows: Walter I. Russell comes to the Coun-

cil as President-elect. Dr. Russell has previously served as a member of the Council as Councilor from New Haven County. Carl E. Johnson succeeds Frank H. Couch as treasurer. There will be a vacancy in the category of "Officer of the American Medical Association" because of the death of Thomas P. Murdock. Ralph T. Ogden continues as a member of the Council as Councilor-at-Large. John N. Gallivan continues as a member of the Council as Delegate to the American Medical Association. Harold M. Clarke succeeds Dr. Gallivan as Councilor from Hartford County. Stewart P. Seigle succeeds Dr. Clarke as Alternate Councilor from Hartford County. Willard E. Buckley replaces F. Erwin Tracy as Councilor from Middlesex County and Norman H. Gardner has become Alternate Councilor from Middlesex County. Alfred Schiavetti succeeds Joseph Kristan as Councilor from Tolland County and Ralph B. Thayer is Alternate Councilor from Tolland County.

The resignation of Olan Meeker as a member and Chairman of the Committee on National Legislation was presented and accepted with regret. Dr. W. Zeph Lane, Darien, was appointed to be a member of the Committee to replace Dr. Meeker from the Fourth Congressional District and Dr. James S. Missett, Hartford, was appointed the Chairman of the Committee.

The resignation of Olan Meeker as a member of the State Committee on Public Relations was presented and accepted. Dr. E. Tremain Bradley, New Canaan, was appointed to succeed Dr. Meeker as a member of this Committee.

The resignation of William G. H. Dobbs as a member and Chairman of the Committee on Public Relations was presented and accepted with an expression of appreciation for Dr. Dobb's long service as Chairman of this Committee. Dr. Ralph L. Gilman, Storrs, was appointed to be a member of the Committee in place of Dr. Dobbs and Harry C. Knight, Middletown, was appointed the Chairman of the Committee.

The resignation of Milton M. Lieberthal, Bridgeport, as member of the Committee on the State Blood Bank and the Committee on the American Medical Education Foundation was accepted. It was voted that Dr. Morris P. Pitock be named a member of the Committee on the State Blood Bank and that the Fairfield County Medical Association be asked to nominate a member of the Committee on the American Medical Education Foundation.

It was voted that Dr. C. Louis Fincke, Stamford, be nominated as a member of the Board of Directors of Connecticut Medical Service to succeed the late Thomas P. Murdock.

It was voted that Dr. Elwood Weise, Bridgeport and Dr. Reginald Gillson, New Haven, be renominated to the Governor to continue on the State Board of Examiners of Hypertrichologists.

It was voted that Oliver L. Stringfield be named as a member of the Committee on Accident Prevention to succeed Stuart P. Joslin who did not wish to serve on the Committee further and that Bernhard Rogowski, New Haven, be named an additional member of the Committee. It was further voted that Gaert Gudernatch, now Chairman of the Committee on Rural Health, become a member of the Committee on Accident Prevention to replace Norman H. Gardner.

It was voted that an additional allotment of \$100 be made to the budget of the treasurer's office to meet the increased charges of Seward & Monde, Society auditors.

The organization and operation of the Murdock Scholarship and Loan Fund was discussed at length and it was voted that the Chairman and executive secretary appoint a subcommittee from the Council to study the details of this program and report to the Council at an early date. Later during the meeting the following appointments were made: Chairman, I. S. Otis, Thomas J. Danaher, C. Louis Fincke, Creighton Barker.

There was discussion of "A Project to Develop and Demonstrate Methods for an Evaluation of Obstetric and Newborn Services in Hospitals in Hartford County." Dr. Weld explained the project and moved that the Council give its approval to the project and it was voted so.

"Standards and Recommendations for Hospital Care of Maternity Patients" that had been distributed to members of the Council at the meeting on March 27 were presented for discussion. The secretary explained that the Society's Committee on Hospitals had this matter under advisement and had appointed a subcommittee to give detailed consideration to the subject and report to the Committee at its next meeting on May 15 and that Dr. Gildersleeve, chairman of the Committee on Hospitals, had asked that the Council delay definitive action until after the Committee on Hospitals could report. This was agreed to but the "Standards and Recommendations" were discussed and certain con-

clusions reached which the secretary was directed to communicate to the Committee on Hospitals as being the opinions of the Council. These were principally to the effect that the qualifications for the Chief or Chairman of Obstetric Department on page 2 were too exacting and that it would be impossible to meet the stated qualifications in many small community hospitals. It was proposed that a statement "or equivalent training or standing in the community" be added appropriately to this paragraph. It was also agreed that the same extended definition of qualification be added to the two paragraphs concerning consultants on page 7 and the two paragraphs relating to cesarean section on page 7.

Many questions were raised concerning the "Recommendations for the Prevention and Treatment of Toxemias of Pregnancy" on pages 5 and 6 but no definite recommendations for changes were made.

It was pointed out that hospitals operated by the Roman Catholic Church could not include in their operative procedure the recommendations relative to therapeutic abortion and sterilization.

The secretary was directed to address a communication to the members of the House Committee on Ways and Means of the House of Representatives of the United States and to all Connecticut representatives in the Congress of the United States stating the Society's favorable opinion on HR9 and HR10, the so-called Jenkins-Keogh bills that would permit self-employed persons, such as physicians, to make tax exempt contributions to personal retirement funds.

Dr. Weld spoke of the resolution passed by the House of Delegates on April 30 on recommendation of the Committee on Mental Health advocating that a study be made of drug addiction in Connecticut. He pointed out that the recommendation in the report of the Committee on Mental Health would entail a great deal of work and that perhaps the Society should not undertake it. In discussion that followed, Dr. Gibson, Speaker of the House, pointed out that the recommendations contained in the report of the Committee on Mental Health had been changed by the Reference Committee of which Dr. Franklin S. Dubois was Chairman and that the resolution formally passed by the House was not as far-reaching and did not commit the Society to the extensive project that was proposed by the Committee on Mental Health.

Dr. Danaher opened a discussion on the status of SB404 relating to the amendment and broadening of the enabling act under which Connecticut Medical Service operates (see minutes of meeting of January 31, 1957). He stated that according to recent information the Committee on Insurance of the General Assembly did not intend to report the bill out and that the only way that it could be brought to the floor of the House for consideration would be a petition from members of the House. Dr. Danaher suggested that all members of the Council communicate with their representatives in the House urging them to make efforts to have this bill reported. The secretary asked that members of the Council make contact with the members of the Committee on Insurance and a list of their names and addresses was distributed.

It was voted that the secretary prepare the resolution on social security for physicians for presentation to the House of Delegates of the American Medical Association at its New York Meeting in June, as voted by the House of Delegates of this Society at its Annual Meeting on April 30.

Dr. William H. Keeler, director of Medical Health Services, Office of Civil Defense, State of Connecticut, joined the Council by invitation to explain and discuss the necessity for the appointment of a Casualty Planning Committee to cooperate with the State Office of Civil Defense. Dr. Keeler spoke at some length on this subject and other phases of Civil Defense, particularly the part that physicians should take in the program. A few questions were discussed that were directed to Dr. Keeler and after discussion which consumed 45 minutes he was excused from the meeting. It was then voted that the Chairman of the Council should appoint a Casualty Planning Committee as requested by Dr. Keeler.

An invitation was presented for the Society to designate a member to attend the Fifth Annual National Medical Civil Defense Conference given by the Council on National Defense of the American Medical Association on June 1 in New York during the Annual Meeting of the Association. It was voted that Royal A. Meyers, alternate councilor from Litchfield County be designated to represent the Society at the conference and Dr. Meyers agreed to attend.

The meeting adjourned at 6:15 following which the gentlemen of the Council dined at the Lawn Club.

Meetings Held During May

- May 1—Annual Meeting
- May 2—Annual Meeting
- May 6—Medical Legal Conference
- May 8—Connecticut Health League
- May 9—Council
- May 13—Committee on Eye Care
- May 14—Committee on School Health
Connecticut Medical Examining Board
- May 15—Committee on Maternal Mortality
Committee on Hospitals
- May 22—Committee on Accident Prevention
- May 23—Committee on Professional Relations
- May 27—Connecticut Health League

County Association Officers

FAIRFIELD COUNTY

President: R. Harold Lockhart, 144 Golden Hill Street, Bridgeport.

Vice-President: G. Gray Carter, 29 Hillside Drive, Greenwich.

Secretary: Michael A. Dean, 881 Lafayette Street, Bridgeport.

Executive Secretary: Mr. Arnold P. Olson, 211 State Street, Bridgeport.

Treasurer: Thomas J. Tarasovic, 49 Dover Street, Bridgeport.

Councilor: C. Louis Fincke, 21 Broad Street, Stamford.

Alternate Councilor: John P. Gens, 64 Wall Street, Norwalk.

HARTFORD COUNTY

President: John N. Gallivan, 400 Main Street, East Hartford.

Vice-President: Phillip Cornwell, 85 Jefferson Street, Hartford.

Secretary-Treasurer: Benjamin L. Salvin, 242 Trumbull Street, Hartford.

Executive Secretary: Mr. Joseph L. Gordon, 230 Scarborough Street, Hartford.

Councilor: Harold M. Clarke, 73 Cedar Street, New Britain.

Alternate Councilor: Stewart P. Seigle, 85 Jefferson Street, Hartford.

LITCHFIELD COUNTY

President: John R. Elliott, Canaan.

Vice-President: Francis Gallo, 442 Main Street, Winsted.

Secretary-Treasurer: Isadore S. Goldberg, 24 Church Street, Torrington.

Councilor: Frank D. Ursone, Greenwoods Road, Norfolk.

Alternate Councilor: Royal A. Meyers, 162 Main Street, Watertown.

MIDDLESEX COUNTY

President: Vincent J. Vinci, 70 Crescent Street, Middletown.

Vice-President: Harry St. John Whiting, Connecticut State Hospital, Middletown.

Secretary-Treasurer: Clarence W. Harwood, 111 College Street, Middletown.

Councilor: Willard E. Buckley, 195 South Main Street, Middletown.

Alternate Councilor: Norman H. Gardner, 43 Main Street, East Hampton.

NEW HAVEN COUNTY

President: Charles T. Flynn, 41 Trumbull Street, New Haven.

Vice-President: George G. Fox, 147 West Main Street, Meriden.

Secretary-Treasurer: Cole B. Gibson, 364 Whitney Avenue, New Haven.

Councilor: Israel S. Otis, 165 West Main Street, Meriden.

Alternate Councilor: Christopher E. Dwyer, 18 Pine Street, Waterbury.

NEW LONDON COUNTY

President: E. Roland Hill, 43 East Main Street, Mystic.

Vice-President: Harold Bergendahl, 63 Broadway, Norwich.

Secretary-Treasurer: Clifford Wilson, Clinic Drive, Norwich.

Councilor: Henry A. Archambault, 2 North Second Avenue, Taftville.

Alternate Councilor: Richard M. Starr, 273 Williams Street, New London.

TOLLAND COUNTY

President: Roy C. Ferguson, 57 Union Street, Rockville.

Vice-President: John F. Hughes, 9 Colton Road, Somers.

Secretary-Treasurer: R. Bruce Thayer, Jr., Main Street, Hazardville.

Councilor: Alfred Schiavetti, 11 Church Street, Stafford Springs.

Alternate Councilor: Ralph B. Thayer, Main Street, Somers.

WINDHAM COUNTY

President: James F. Jones, 39 Broad Street, Danielson.

Vice-President: Mervyn H. Little, 715 Main Street, Willimantic.

Secretary-Treasurer: Frederick A. Beardsley, 59 Church Street, Willimantic.

Councilor: Edward J. Ottenheimer, Windham Community Hospital, Willimantic.

Alternate Councilor: Ralph L. Gilman, Sotrrs.

New Members

FAIRFIELD COUNTY

John E. Borowy, Stamford
 Thomas L. Bucky, Westport
 Milton Cooper, Bridgeport
 Leonard Flom, Fairfield
 Henry J. Fox, Bridgeport
 Nicholas P. Gill, Bridgeport
 Geraldine R. Huss, Greenwich
 Marjorie E. J. Shafto Jameson, Danbury
 Thomas P. C. Jameson, Danbury
 Stewart A. King, Stamford
 Alexander Lowen, New Canaan
 Albert S. Lyons, Bridgeport
 Richard C. Manjoney, Bridgeport
 Howard S. Morrow, Danbury
 John J. McDermott, Danbury
 Erwin D. Niesyn, Stratford
 Ramona M. Riccio, Bridgeport
 Nathaniel Selleck, Jr., Brookfield
 William O. Sires, Newtown
 Frederick Van Poznak, Ridgefield
 Guy W. Van Syckle, Danbury
 Joseph D. Waxberg, Greenwich
 Thomas M. Winston, Bridgeport
 Richard S. Banfield, Jr., Stamford
 Timothy F. Nolan, Stamford
 Elias Savitsky, Stamford

HARTFORD COUNTY

Lawrence B. Ahrens, New Britain
 Morton Bedrick, Hartford
 Donald T. Book, Hartford
 Roger S. Beck, Hartford
 Richard M. Demko, Manchester
 Alan A. Dun, Newington
 Arnold Fieldman, Hartford
 James B. Given, III, Hartford
 Stanley B. Freeman, New Britain
 Walter E. Gustafson, East Hartford
 Charles Q. Griffith, Jr., Manchester
 William E. Hart, Hartford
 Martin S. Kleckner, Jr., Hartford
 Henry B. C. Low, Hartford
 Lawrence L. Malinconico, Hartford
 Hugh Z. Maray, West Hartford
 J. Arnold Mittleman, Hartford

Douglas J. Roberts, Hartford
 William E. L. Stewart, New Britain
 Harry J. Tamoney, Jr., Hartford
 Benjamin D. Thaw, Hartford
 John B. Thomas, Hartford
 Jacob P. Warren, Newington
 Edmund T. Welch, Jr., Hartford

LITCHFIELD COUNTY

William W. Bassford, Watertown
 Irving L. Cabot, Washington

MIDDLESEX COUNTY

Felix G. Sheehan, Middletown
 Donald S. Sweitzer, Deep River
 Michael Villari, Middletown

NEW HAVEN COUNTY

Harold L. Atkins, New Haven
 Charles L. Buxton, New Haven
 Norman A. Cameron, New Haven
 Dante Chiappinelli, Milford
 George L. Cohn, New Haven
 Arthur J. Deikman, West Haven
 Leonard A. Fasano, New Haven
 Harry W. Fister, Waterbury
 Ira S. Goldenberg, New Haven
 Frederick W. Hehre, New Haven
 Walter Herrmann, New Haven
 Daniel Kahn, Meriden
 Robert G. LaCamera, New Haven
 Stanley R. Laviates, New Haven
 Aaron B. Lerner, New Haven
 Marguerite R. Lerner, New Haven
 William F. Lynch, Milford
 Douglas A. Rofrano, Wolcott
 Walter Tietz, West Haven
 Francis H. Tonkonow, Meriden
 Adolph Wehrli, Meriden
 Bernard D. Zuckerman, New Haven

NEW LONDON COUNTY

Ronald A. Mariani, New London
 John L. Smalldon, Norwich

WINDHAM COUNTY

Donald F. Rayl, Putnam
 Murray Rosenberg, Willimantic

THE HISTORIAN'S NOTE BOOK

JOSIAH BARTLETT AND THE FOUNDING OF THE NEW HAMPSHIRE MEDICAL SOCIETY

THE year 1791 opened auspiciously for the American people. The old confederation, which had been aptly called "a rope of sand," had given way to the new constitution, and the union of the States was so firmly secured that it seemed likely to be everlasting. The dawning prosperity reconvinced the people that in union there was not only strength, but mutual encouragement and helpfulness and advancement. In politics, in mercantile affairs, and in trade, organization was actively going on, and pushing for advantage.

It is not strange that the physicians of New Hampshire, full of the spirit of the age, the events of which they had so largely helped to shape, should have appreciated the advantages in their own sphere of combining together for their mutual benefit. The absolute necessity for this, if there was to be any great advance beyond the existing state of knowledge, was greater in those days than now. Books were scarce and high, and it required six months to get one from Europe, and there were no medical journals. Only one work of any magnitude, "Smellie's Midwifery," reprinted in Boston in 1786, had been published here.

Yet these physicians were learned men for their day. They had studied with their fathers and other men already eminent. Amos Gale, who was admitted at the first meeting of our Society, had several students; and his son, subsequently admitted, had twenty.

During the war of the Revolution, to which our States furnished a full quota of surgeons, the facilities for interchange of views and facts between the physicians of different parts of the country were great. Surgeons well learned in their profession came also from abroad and added to the common stock of knowledge, but with the close of the war this method of gaining information was nearly at an end, and on returning to their native villages our medical ancestors were isolated.

Moreover, there was sadly needed some fixed standard of qualification for students about to enter upon practice. There were only three medical schools in the whole country at this time—Harvard, founded in 1783, the University of Pennsylvania in 1764, and King's college, in New York, in 1768—two of them so distant as to be practically inaccessible; and it required quite a sum, for those days, to go to Boston to reside. Up to the close of the century these schools had not graduated two hundred and fifty. The Massachusetts Medical Society, which had its first meeting in 1782, was already issuing licenses, and there was need of a similar tribunal in New Hampshire.

Moved by these and perhaps other considerations, a petition signed by nineteen physicians, from thirteen different towns, was presented to the legislature, and a bill was passed by the house, and signed, February 16, 1791, by Josiah Bartlett, president, incorporating these physicians by the name of the New Hampshire Medical Society. The nineteen men were Josiah Bartlett of Kingston, our all worthy founder, Joshua Brackett, Ammi R. Cutter, Hall Jackson, and John Jackson of Portsmouth, James Brackett of Lee, Moses Carr of Somersworth, William Cogswell of Atkinson, Ezra Green of Dover, Osgood Kendal of Peterborough, Benjamin Page, William Parker, Jr., Nathaniel Peabody, and Samuel Tenney of Exeter, William Page of Charlestown, Ebenezer Rockwood of Wilton, John Rogers of Plymouth, George Sparhawk of Walpole, and Isaac Thom of Londonderry.

These were, nearly all of them, men of much more than ordinary ability. They were distinguished men. It would be difficult to match them now among the profession in this State—outside the members of this Society. We are too apt to think that knowledge began in our time, if not in us. Hannibal was a great general although he did not have rifled cannon and dynamite, and these men were great physicians for

From "The Story of the New Hampshire Medical Society," Nashua, N. H., Phaneuf Press 1941

their time without antipyretics and tuberculin. They were thoughtful, serious, self-reliant, fertile in expedients, and they had learned to turn to the best account what they knew.

The long struggle of the colonies, culminating in the war for independence, was very potent in developing the highest traits of character, and it follows from this, almost as a corollary, that the Continental congress was probably the wisest assembly that ever convened. There were two New Hampshire physicians in it, Josiah Bartlett and Matthew Thornton, sent by the State to heal the body politic, which, according to Cotton Mather, "was sicke nighe unto deathe." Both became signers of the Declaration of Independence, Josiah Bartlett having been the first member to vote for it, and the first to sign it after John Hancock, the president. He seems to have been providentially placed where he was. He was a physician, and God knew he would not hesitate to assume the responsibility. He had many times taken the responsibility at the birth of a man. Why should he shrink at the birth of a nation, or lag at the birth of a medical society?

Matthew Thornton, at the time of the founding of this Society, had retired from practice, being then seventy-seven years old. An address on this historic occasion would not be complete without a brief account of these men.

The Bartlett family, which has furnished seven members to our Society—three of them having been presidents, and another a secretary—descended from ancestors who went from Normandy to assist in conquering England. They settled in the south of England whence one branch of it not sated by conquest, came to America to do great service in after years in conquering England again. Richard Bartlett settled in Newbury, Massachusetts, about 1635. His son Richard remained in Newbury, and this Richard's grandson, Stephen, married Hannah Webster, and settled in Amesbury, where Josiah was born November 21, 1729.

In his youth Josiah must have had fair advantages for he acquired a fair knowledge of Greek and Latin, and advanced so rapidly that at the age of sixteen he began to study the profession he subsequently adorned, with Dr. Ordway, a distant relative. He had access to the libraries of the neighborhood, and especially to the choice and extensive one of Rev. Dr. Webster, a relative on his mother's side, an able and learned divine, whose deep interest

and friendship, afterward mutual, continued through life.

In 1750, at the early age of twenty-one, young Bartlett began to practise in Kingston, residing in the family of Rev. Joseph Secombe. And, by the way, this constant association with clergymen undoubtedly had an influence in developing and confirming the religious side of his character, which was conspicuous throughout his life, but it did not hamper his independence in thinking, for, while his relatives were Calvinists, he became a believer in man's free agency and accountability.

When he had been in practice two years he was attacked by a fever which came near proving fatal, and we are told that when he found himself to be sinking he asked two young men, who were watching him, to get him some cider. They objected that it would be contrary to the order of his physician, but as the physician had pronounced the case hopeless they yielded to his persuasions, and the patient took the cider during the night, improving with every draught. In the morning a profuse perspiration came on, and the fever abated. After this he based his practice not on arbitrary rules, but on the condition of the patient, "treating the patient," as we say nowadays, "instead of the disease."

In 1754-'55, when he was thirty-five years old, an epidemic of cynanche maligna (diphtheria as we now term it) broke out, which was very fatal under the depleting and antiphlogistic course of treatment then employed. He decided on a different course, and, when his own child was smitten, administered Peruvian bark with happy effect. These are, from one point of view, trifling incidents, but they are related to show that he was an original, independent thinker, with "the courage of his convictions." These traits secured for him an extensive and lucrative business.

There is one thing more we know about Dr. Bartlett, and that is a very important one. He always displayed actively a zealous interest in the welfare of his profession. He was not only the founder of this Society, but he attended its meetings. Amid the onerous cares of his public life he took time to attend. When there was no quorum he was present. The doctor who keeps away from societies is more likely to become opinionated, selfish, and narrow-minded.

In June, 1793, while governor of the State, he was present, but declined a reelection to the office of

president. Whereupon the Society entered the following upon its records:

"His Excellency Governor Bartlett having signified to this society that the discharge of the arduous and important duties of his office as first magistrate of the state, with various other concerns, must necessarily engross his whole attention, and that notwithstanding he should ever aim to promote the true interest of the Society, yet it would be inconvenient for him any longer to hold the office of President; wherefore, Resolved unanimously that the united thanks of the Fellows be given to His Excellency Governor Bartlett for his very polite and friendly attention and patronage in forming and supporting the Medical Society; and they very much regret his declining to accept the office of President, and request his advice, patronage, and attendance at the meetings whenever he can make it convenient.

"(signed) Nath. Peabody, Vice-president."

Upon receipt of this, His Excellency returned, the same day, the following reply:

"Gentlemen of the New Hampshire Medical Society:

"The unexpected resolve of thanks, presented me by your committee, for the small service I have been able to afford the Medical Society I consider as an instance of polite attention and regard they mean to pay to such persons as may in any manner endeavor to promote the public happiness.

"I have long wished that the practice of medicine in this state (upon which the lives and healths of our fellow citizens depend) might be put under better regulations than it has been in times past, and have reason to hope that the incorporation of the New Hampshire Medical Society (if properly attended by the Fellows) will produce effects greatly beneficial to the community, by encouraging genius and learning in the medical science and discouraging ignorant and bold pretenders from practicing an art of which they have no knowledge.

"That the members of the Society may be useful to themselves and the public, and enjoy the exalted pleasure and satisfaction that arise from a consciousness that they have contributed to the health and happiness not only of their patients, but by communicating to others the knowledge and cure of disease, to the general happiness of the human race, is the ardent wish of, Gentlemen, your very humble servant,

"Josiah Bartlett

"Concord, June 19th 1793"

The public, political life of our founder is not of so much importance to us on this occasion, and yet it can hardly be left out of account if we would duly estimate his character. To begin with, he possessed in an eminent degree the qualities people look for when they seek a leader in a trying emergency. He was honest, self-reliant, cool, decisive, of good judgment. His profession tended to make him all that, and, the clergy excepted, he was educated above the people around him.

He first appears in public life as representative in the legislature of the province of New Hampshire, Benning Wentworth being governor. Dr. Bartlett took the side of the people against the increasing encroachment of British power. To win his support, Gov. Wentworth appointed him justice of the peace, but he declined to serve. He became member of the Committee of Safety, and a member of the convention called to choose delegates to a general congress in Philadelphia in September, 1774. He and John Pickering of Portsmouth were chosen to be these delegates, but, his house having been recently consumed by fire, he was obliged to decline. In September, 1775, he was appointed to command a regiment by the first Provincial congress, of which Dr. Matthew Thornton was president.

On August 23, 1775, he was chosen to the Continental congress, and took his seat on the 16th of September. On the 23rd of January, 1776, he was reelected, and on June 12th was appointed on the committee to prepare a form of confederation. In December, 1776, he was reappointed delegate, but he soon came home, worn out by his unceasing services and anxieties.

But he was not idle, for he was soon providing supplies for Stark at Bennington, and rendering other public services.

In August, 1778, he was again a delegate, but he resigned in October to attend to his domestic concerns, which had been sadly neglected.

In 1779 he was appointed chief-justice of the court of common pleas and muster-master of the troops then being raised for three years of the war. In 1782 he was promoted to be justice of the superior court, and in 1788 chief justice. In 1790 he was chosen president of New Hampshire, and so continued till 1793, when elected the first governor. He was elected the first senator to the first congress of the new confederation in 1789, but declined.

Of the votes cast for governor in 1792, he received 8,096, and there were 297 scattering. In 1793, out of 9,854 votes he received 7,388, or three fourths of the whole, although John Langdon and others

were in the field against him. He was also one of the electors of president and vice-president in 1792.

Is it any wonder that on the 29th of January, 1794, he resigned all public positions on account of increasing infirmities? But his repose in private life was of short duration, for, on the 19th of May, 1795, in the sixty-sixth year of his age, he died quite suddenly of paralysis.

By his excellent wife, whose maiden name was Mary Bartlett, he had three sons, each of whom became distinguished—Levi, Josiah, and Ezra.

He was honored by every gift of office New Hampshire could bestow, and yet he was so discreet and open-hearted and honest that he never provoked hostility or excited envy. He may not have been what is called a great man, yet he was fully adequate to every position to which he was called, and they were many and very important and very trying ones in the crisis of the nation's history. The people trusted him, and he trusted in God, and neither was disappointed.

The following, not quoted in his biographies, shows the temper of his mind. In a letter to Gen. Folsom, after the evacuation of Long Island, concerning preliminary negotiations looking to peace, he writes,—

What the congress will do is at present uncertain, but I hope they will be directed by the Supreme Disposer of all events to do in this and every other affair before them that will be most conducive to the safety and happiness of these American states.

Like Josiah, king of Judah, "he did that which was right in the sight of the Lord . . . and turned not to the right hand or to the left."

How Improve Infant Mortality Rates

This year some 300,000 American babies will have a first birthday who would have died in infancy if they had been born forty years ago. Behind this dramatic improvement lie two major factors—the medical progress of the last few decades and the public's increasing willingness to take advantage of this progress.

Many U. S. mothers have amply shown their interest in adequate prenatal care, deliveries in the hospital rather than the home, and preventive medical care for infants in physicians' offices and well-baby clinics. The results are clearly demonstrated by the declining frequency of death and serious illness among infants.

Yet there is room for further improvement. More than 100,000 infants died last year, and there is evidence that many of these deaths could have been prevented. An authoritative study sponsored by the New York Academy of Medicine* indicated that more than half the early neonatal deaths in full-term deliveries might have been prevented by better health practices, both on an individual and a community basis.

But how is continuing improvement to be accomplished? Although remarkable medical advances have been made in recent years, and it is likely that further strides will be made in the future, the success of medical science will continue to depend on better understanding and liaison between hospitals and doctors on the one hand and the public on the other.

Certainly authorities agree that there is room for improvement on the professional level. Although reliable nationwide statistics are lacking, various studies suggest that the causes of more than half the current total of fetal and early neonatal deaths are unknown or ill-defined. As a result, medical and hospital leaders continue to stress the need for further research in the causes and prevention of infant deaths, as well as further gains in medico-administrative relationships in hospitals, in medical record-keeping and in the exchange of technical knowledge among all parts of the country.

Just as fundamentally, however, further progress depends on communicating more adequately with the portion of the U. S. public that is not now taking full advantage of existing knowledge about proper maternity and infant care. By and large, infant mortality rates are highest among the socio-economic groups who today show the least inclination or ability to use modern medical services and modern health practices. However, there is latitude for improvement in all income groups—improvement which can come as modern knowledge is more broadly used by the public.

There is no easy answer to the question of how to make every group want to take advantage of modern medical facilities; some people may not always be receptive to educational processes and still others have never really been exposed to them. But it does seem obvious that any substantial further improvement in infant mortality must have impact on all groups if we are to bring the potentials of medical science to everyone.

*Kohl, Schuyler G.: *Perinatal Mortality in New York City*, Harvard University Press, Cambridge, 1955.

Special Article

MUTUAL MEDICOLEGAL PROBLEMS

F. LESLIE HART, *Boston, Massachusetts*

IT is an honor to address a group of men of such distinguished ancestry. The office of coroner, or "crowner" goes back in English history to Anglo-Saxon days. The Medical Examiner, in New England, and in many other States, is the legal descendant of the coroner. The National Office of Vital Statistics estimates that probably 20-25 per cent of the 1½ million deaths registered annually in this country come within the jurisdiction of the coroner or the medical examiner.

FOOD POISONING

The paths of Medical Examiners and the administration of the Federal Food, Drug, and Cosmetic Act often intersect, and at times coincide. Let us consider "food poisoning." This phrase often has rather vague connotations, particularly in the public press. It may mean that the food ingested was contaminated with viable micro-organisms, whether before or after it leaves the factory, with chemicals, carelessly or intentionally added, or it may mean an illness or death of undetermined origin. If death results, it is your legal duty to investigate, and to determine the cause of death. The task of the Food and Drug Administration is to ascertain whether the suspected food traveled in interstate commerce and, if so, to determine the origin and the identity of the contaminant.

Violations of the Food, Drug, and Cosmetic Act involving hazards to health are given top priority by our field offices. All outbreaks or cases of illness in which food is suspected as a causative agent are promptly investigated. If a commercially prepared food is found to have caused the illness, that food is promptly removed from the market, and the manufacturer of that food, if it moved interstate, is subject to criminal prosecution in Federal Court.

In all cases our inspectors are instructed to interview the stricken persons, or their close relatives, to ascertain the food or foods involved and the en-

The Author. *Chief, Boston District Food and Drug Administration*

SUMMARY

The author gives instances in which the duties of Medical Examiners coincide with the responsibilities of the Federal Food and Drug Administration. FDA promptly investigates all outbreaks, or cases of illness or death in which a food or drug is suspected as the causative agent. If such food or drug has travelled in interstate commerce it is promptly removed from channels of trade—examples are given.

A plea is made for more accurate reporting of causes of death or illness, and of adverse reactions of drugs. Efforts by FDA to control illegal sales of dangerous drugs are discussed.

vironmental conditions under which the food was stored, prepared and consumed, and to obtain, if possible, samples of the food, stools, and vomitus, any possible causative agents present, such as insecticides, silver polish, sources of carbon monoxide, etc. If medical attendance occurred, the inspector interviews the patient's physician. If local health authorities or Medical Examiners have investigated, these authorities are interviewed, their laboratory reports studied; the inspector offers to cooperate in every way with these officials, and acquaints them with his own findings in order to speedily identify the causative agent and remove it from the market. Since State health officials usually have embargo powers, and we do not, these officials are asked to quarantine any suspected commercial stocks of foods until the investigation is completed.

Polluted natural waters may be a source of contamination. Normally correction of such conditions is a function of State or local health officers. Floods do occur at times, as you here in Connecticut well

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know. At such times warehouse stocks or retail stocks of foods, liquors or drug become immersed in sewage-contaminated flood waters. This of course presents a direct hazard to public health. When such disasters occur a unified task force is set up at once, usually before the waters recede, composed of the available staffs of the State and city health and food authorities, and the nearest FDA District. If the flooded area is widespread the State Food Control Officer usually acts as managing director of the group.

Foods shipped in interstate commerce are not frequently implicated in food poisoning. It has been many years since canned food has been implicated as a source of botulism. Outbreaks of gastroenteritis, or salmonellosis are rarely traced to canned goods. I will speak about salmonella in another connection later.

Annual review by the Food and Drug Administration of reports of food poisoning reveals that the contamination in the great majority of cases occurred in the restaurant, or home, at the time of preparation for serving. Poor refrigeration is another factor contributing to a large number of incidents.

The prevention of contamination of food during manufacture or subsequent storage is an important and continuing responsibility of the Food and Drug Administration. Our field inspectors play an important role here. They are continually inspecting the food factories and food warehouses, pointing out to management the need for better sanitation, better laboratory control. Prevention of insect and rodent infestation is a never-ending job in these establishments. Often our inspectors observe an incipient attack by these pests, or even a major invasion, that has occurred unnoticed, or has recklessly been allowed to develop. Sometimes management takes drastic control methods, without much forethought on the means used. Too often have our inspectors seen unwise use of DDT spray in a dairy, so that the milk is contaminated, or promiscuous scattering of poison bait, such as strychnine-soaked wheat, or Warfarin. They have even seen open cups of 1080 (sodium fluoroacetate) sitting on bags of flour, or on the floor by open boxes of nuts, to kill mice or rats. When such conditions are found the management is warned immediately of the hazard to health involved.

Inspectors in agricultural districts are continually checking on the application of insecticides to grow-

ing fruits and vegetables. We realize it is necessary to use these compounds if we want good crops. However, the residues remaining must be carefully controlled so that toxic amounts are not present when the food reaches the consumer. A recent amendment to the Act authorizes FDA to establish tolerances for pesticide residues on raw agricultural products. These are set at levels which have been proven to be safe to consumers. In some cases these tolerances are zero, in others as low as 0.1 part per million. Products containing poisonous residues above these tolerances, if shipped in interstate commerce, are subject to seizure, and the shipper subject to prosecution.

Let me close this topic by citing some examples of foods removed from the market because they were found to contain some foreign toxic ingredient. These "case histories" were drawn from Annual Reports made by the Food and Drug Administration. Coffee beans, and at another time cocoa beans contaminated with lead ore during overseas shipment, cheese that had absorbed lead from boiled linseed oil rubbed on the rind, dried brewers yeast contaminated with Salmonella organisms, imitation grape jelly containing a fluoride (there were nine tons of this product destroyed), meat preservatives containing thiourea, the entire output, some 10 tons, of an Alaska frozen clam packer, which contained a toxin produced by the microscopic plankton, *Gonyaulax*. Time precludes mention of others.

Serious injuries have occasionally been caused by unsuspected defects in commercial products. Let me cite a few examples. Early in November, 1952, laboratory examination of the stools of an infant ill with diarrhea revealed the presence of Salmonella montevideo. The patient had been fed dried egg yolk and the attending physician recognized this egg yolk might be the source of infection. This fact was publicized, and other cases began to turn up, in at least 16 cities, and all from the same brand of food. Contamination was found in certain codes or batches, scattered over the five month production period.

Not so long ago convulsions in infants occurring in various States was traced to a product formulated as a substitute for mother's milk. No chemical or bacteriological contamination could be detected. Later an FDA biochemist noted the symptoms were found to be very similar to those that developed in baby rats fed a diet deficient in vitamin B₆. This was confirmed by pediatricians. When another food was

substituted the convulsions ceased. Both of these foods were voluntarily withdrawn from the market.

BLOOD DYSCRASIAS

In the drug field, cases of blood dyscrasia were found to be associated with the indiscriminate, or prolonged use of the wide spectrum antibiotic chloramphenicol. First reports on this valuable drug showed a low incidence of adverse reactions, and it was promoted on that basis. It was only after some eight million persons had been treated with this drug that physicians noted, and published their observations of its dangerous possibilities. FDA then made a nationwide investigation that disclosed still more cases, including aplastic anemia, many having a fatal termination. This study was reported in the June, 1954 issue of *Antibiotics and Chemotherapy*.

REPORTING SYSTEM

What do these incidents, and many others that I could relate, signify? It means, for one thing, that our reporting system is now inadequate. We need a system that will supplement the normal notification of communicable diseases to local health officers. During the last decade or two the drug manufacturers have given us many potent and effective therapeutic agents. Their full potentialities, whether for good or for harm, cannot be fully known until they have become widely used. A system is needed for the early reporting of the untoward effects of a drug or of a food whenever there is reason to believe that (1) injury follows the administration of that drug or food; (2) infection follows the ingestion of some commercially prepared foods; (3) multiple cases of a disease occur whose etiology is obscure, especially those occurring in institutions, schools, and other large groups, and (4) when ingestion of chemicals or substances commonly used in the home apparently cause illness or injury. These recommendations were made in a paper by Dr. Kerlan, of the Food and Drug Administration, and Dr. Dauer of the National Office of Vital Statistics published in the November, 1955 issue of *Pediatrics*.

I believe that many of you heard me speak on the need for more informative labeling of these common household products, cleaning fluid, furniture polish, metal polish, and the like. Other than to mention the subject, I shall not take time to dwell on it now.

I would like to refer back to my remarks on the

need for better reporting on adverse reactions of drugs.

The Food and Drug Administration and the American Association of Medical Record Librarians, in cooperation with the American Medical Association and the American Society of Hospital Pharmacists, are now undertaking a joint pilot study at five hospitals to ascertain the practicability of channeling the combined drug-reaction experience of physicians and hospitals throughout the country to a central repository for evaluation, and subsequent dissemination to all concerned with medicine and public health protection. Because of the crucial role FDA plays in the field of drug therapy, that agency has been named frequently as the logical place for such a repository. You here will be interested in knowing that one of your neighboring hospitals, St. Joseph's of Providence, is one of the five hospitals cooperating in this pilot study.

Dr. Katherine Bain, of the Children's Bureau, in a review of vital statistics on accidental poisoning in young children (*J. Pediatrics*, June 1954) points out that in statistics on deaths from accidental poisoning of children under five years, occurring in the United States during 1949-1950, about five per cent of these deaths are listed "unclassified" as to the cause of death. We have frequent need for reviewing death certificates, or statistics assembled therefrom, in connection with investigations on untoward reactions of drugs, as well as for other reasons. In such instances these certificates serve their purpose more fully when they clearly reveal the causative agent rather than a general statement "due to drug" as the cause of death. It does seem that there is a need for particular acquaintance of physicians with this problem so that they will better appreciate the need for accurate diagnosis of each case to aid in prevention of similar accidents and to have fully informative records.

MISUSE OF DANGEROUS DRUGS

Now I will discuss a problem that has come within the experience of each one of you here. That is, the misuse of dangerous drugs, drugs that should be used only under the supervision and care of the attending physician. In 1952 the Congress clarified the Food, Drug, and Cosmetic Act through an amendment which, in effect, divided all drugs and medicines into two classes, those that could be dispensed over the counter without a prescription and those that could be dispensed only on a prescription

issued "by a practitioner licensed by law to administer such drug." As you all know, an illicit traffic has developed in some of these drugs, the main offenders being the amphetamines and the barbiturate drugs. While the vast majority of pharmacists sell these drugs only on prescription, addicts seem always to be able to find some source of supply. Often this has been outside of the usual drug trade channels. We have uncovered the sale of barbiturates in penal institution and veterans' homes, by peddlers on street corners, operators of "flop-houses," clerks in grocery, or even in jewelry stores, ice-men and others.

You have undoubtedly heard of the misuse of amphetamines by truck drivers, to enable them to keep awake on long hauls. A countrywide investigation by FDA revealed that drivers bought these drugs at gas stations, truck stops, roadside restaurants or from peddlers. As a result of this investigation 43 of these suppliers were simultaneously indicted, in various judicial districts, for their part in this illegal traffic. High school students also buy amphetamine drugs, just for a thrill. There is a similar under-cover traffic in the barbiturates, which, as you know, are habit forming. To show you the extent of our concern over this traffic, out of 149 drug cases prosecuted during fiscal year 1954, under the Food, Drug, and Cosmetic Act, 131 were based on the illegal sale of prescription drugs.

I want to say here that it is not our policy to investigate the sales practice of drugstores unless we have received complaints concerning the illegal practices of that store. Such complaints come from parents of teen-aged children, from the husband or wife of an addict, from hospitals, and from health officers, medical examiners, and other public servants. Medical examiners have at times been instrumental in our uncovering of new sources of supplies of these drugs by letting us see prescription boxes, or other containers, found in the room, or on the person of victims dying from over-dose of barbiturates, chloral hydrate, or other potent drugs.

You might be interested in the role of a physician employed by the Food and Drug Administration. One of our physicians, Dr. Leo Parmer, in an article in the February, 1956 issue of *Antibiotic Medicine* summarized the qualifications of an FDA Medical Officer by writing a fictitious classified advertisement:

"Help Wanted: Physician completely and expert-

ly trained in all branches of medicine and surgery. Able to give advice relating to the use and misuse of all drugs and devices. Must have sufficient knowledge to assist lawyers in preparation of court case. Willing to travel."

Of course no one physician could possibly qualify. But the Division of Medicine of FDA as a unit is so constituted that its medical officers do all that and more. The physicians composing this unit can consult with FDA experts in the other technical divisions: Nutrition, food, antibiotics, pharmacology, pharmaceutical chemistry. They attend clinics or conferences in their own specialty, and consult with recognized experts in their fields. They keep up to date with the voluminous medical literature. Armed with his own knowledge, and augmented by the facilities at the command of the Division, a Medical Officer prepares a "current consensus of medical opinion" covering the subject under consideration. Such an opinion must be entirely without bias and strictly factual, so that it can stand up in a court of law.

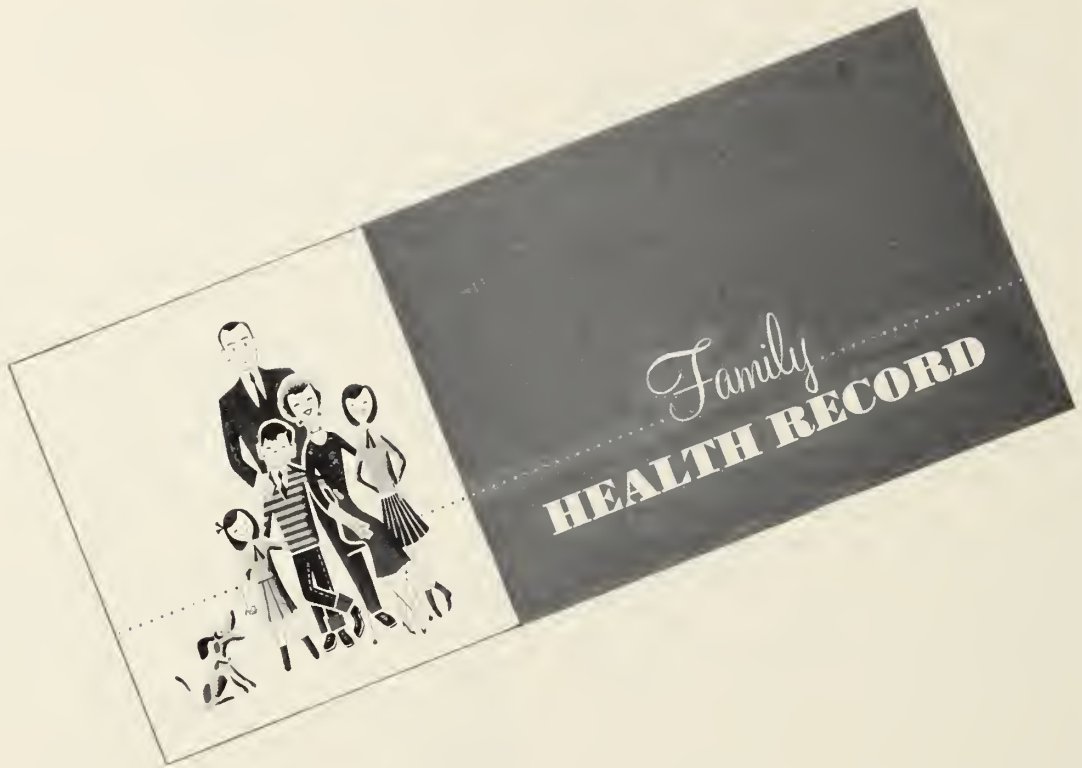
The Division of Pharmacology also employs physicians whose work is in part advisory and regulatory, and in a smaller part, research.

Breath Testing of Alcoholics

The American Medical Association has endorsed breath testing as a quick, accurate and efficient means of determining just how drunk a driver is. A number of chemical breath-testing devices now available to law enforcement agencies can produce evidence on drinkers that should stand up in court, according to the AMA's Committee on Medicolegal Problems. The Association's subcommittee on Chemical Tests for Intoxication has found the breath test to be a scientifically accurate way to arrive at a person's degree of intoxication.

With medicine and the law working together on this problem, it is hoped that an example, which can be followed by other groups, will be set. It is high time that all agencies, groups and individuals—including lawmakers—took steps to curb drunk driving.

Public acceptance of the now proven breath-testing method, combined with rigid enforcement and effective courtroom follow-through could save 10,000 lives each year.



The Family Health Record has been designed to encourage the keeping of basic health information. It provides space for recording dates of immunizations, illness, hospital stays, health insurance data and other useful information.

A well-kept record can be helpful when starting a medical history — and the information can often be used for insurance, camp, school, or other purposes, thus helping to reduce office phone calls.

Use the coupon below if you would like a half-dozen copies of the record to test patient reactions.

CONNECTICUT STATE MEDICAL SOCIETY
160 St. Ronan Street
New Haven 11

Please send six copies of the Family Health Record.

Name

Address

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New Haven County Active in Training Medical Assistants

A special committee to cooperate with secretarial schools in the training of medical assistants has been recommended by the Public Relations Committee of the New Haven County Medical Association.

The recommendation follows several years of committee experience in advising staff members at Quinnipiac College and other schools in the New Haven area which offer courses for secretaries and medical assistants.

The college now offers a two year course for medical secretaries and expansion of the training program is being planned. This would include lectures by guest physicians on pertinent medical topics and a program of actual experience as part-time secretary in a medical office.

Torrington Society Participates in Science Fair

The Torrington Medical Society recently participated in a science fair sponsored by the Rotary Club in that community.

The fair included 130 exhibits by Torrington High School students and featured a display of working models of the inventions of Leonardo Da Vinci.

Prize winning exhibits included a chart of the eight basic life functions of plants and animals which won a special award by the medical association. Other exhibits ranged from wireless transmitters and receivers to models of devices for measuring electrical energy.

Physicians Contribute Record Amount to Medical Schools

Physicians gave well over \$3,000,000 to medical education in 1956, according to a recent report by the American Medical Education Foundation.

The AMEF data includes for the first time information on contributions through independent alumni campaigns of the medical schools.

The report indicates that 84,657 doctors gave a total \$3,320,152.14 to the country's 83 medical schools. This total included \$1,072,727 given through the AMEF by 39,892 doctors, and \$2,247,425 given directly to the medical schools by 44,765 doctors.

The AMEF's million-plus contribution is to be used at the discretion of the schools. The new information shows that most of the contributions made through alumni campaigns are also "unmarked," that is, they may be allocated as the deans of the individual schools see fit.

New Booklet on AMA Services

"AMA in Action," an informative new booklet describing the services of the American Medical Association will be off the presses in June.

The 44 page publication will outline the progress being made in all fields of medical care and point out the various Association services available to physicians and the public. Copies of "AMA in Action" will be sent to AMA officers, trustees and delegates, national opinion leaders, medical schools and pharmaceutical representatives. Limited quantities will be made available to state and county societies for distribution to key officers.

New Poison Control Center in Stamford

A new service for control of poisoning cases was recently established at the Stamford Hospital.

Known as the Poison Control and Information Center, the service is available 24 hours daily and may be used by physicians seeking information concerning poisonous compounds in emergencies.

News Capsule, the official publication of the Fairfield County Medical Association, states that the Center will offer laboratory facilities for emer-

gency toxicology and that a public information program is being planned to acquaint residents of the area with the service.

New Jersey Society Reviews Its Emergency Plans

Pointing to the importance of emergency call plans in the community service area of medical association public relation programs, the Medical Society of New Jersey recently published a checklist for local committees to review the operations of their plans.

The following criteria were suggested:

"A. Is the present system so tautly drawn that individual doctors are assigned to coverage duty on a definite schedule, or is coverage attempted on the basis of haphazard reference to a general list of those who have declared their willingness to take emergency calls?

B. Is there a sufficient number of doctors actively participating, so as not to impose a disproportionate burden on a willing few?

C. Has a definite central agency been established to assign the emergency calls impartially and with a minimum of delay?

D. Have the existence of the system of emergency coverage and the location of the central agency been fully publicized?

E. Under the present system what are the chief complaints of both physicians and public?

F. What constructive suggestions have been offered by both physicians and public for improving the present setup?"

Schering Releases Arthritis Film

A new 16 mm. color motion picture on the uses of steroids in the treatment of rheumatoid arthritis has been released for showing to professional groups by the research division of Schering Corporation.

The film reviews the chemistry, physiology and clinical application of the new "Meti" steroid hormones in rheumatoid arthritis and other collagen diseases. It presents the most commonly accepted theories of adrenal corticosteroid therapy and reflects the current knowledge of the subject.

The 25 minute film, which is the fourth in Schering's series on hormone therapy and the endocrines, was produced by the company's Clini-

cal Research Division and Biochemical Research Department. Three leading rheumatologists and endocrinologists cooperated: Dr. Joseph Eidelsberg, associate professor of clinical medicine at New York University's Post Graduate Medical School and chief of the Endocrine Clinic at University Hospital, New York; Dr. Abraham Kolodin, senior attending in medicine at Mountainside Hospital, Montclair, N. J.; and Dr. Evelyn Merrick, rheumatologist at the Orange Medical Center, Orange, N. J.

The film is available to medical and allied professional groups on loan without charge. "Meti Steroids in Rheumatoid Arthritis" and other Schering films may be obtained by writing to The Audio-Visual Department, Schering Corporation, Bloomfield, N. J.

Poisoning Control Centers Skyrocket to Fame

What was a single seedling in Chicago in 1953 has now spread in all directions—east, west, north, and south. Under the leadership of the Illinois Chapter, American Academy of Pediatrics, a community poison control center was organized in Chicago late in 1953. The guiding spirit was Edward Press, M.D., chairman of the Subcommittee on Poisoning of the Academy's Accident Prevention Committee. Dr. Press is now field director of the American Public Health Association.

Dr. Press brought the story up to date as of March, 1956, in "Poison Control Centers: A New National Movement," published by and reprinted from Occupational Health News, AMA Archives of Industrial Health. There were in operation in November, 1955, centers in 14 cities from Boston to Dallas and nine more in development. The 23 centers going and burgeoning were located in 15 States and the District of Columbia. By March, 1957, 44 were in operation in 18 States and the District of Columbia. Fifteen of the total are in Florida, which prides itself on a network covering the entire State; New York has five; New Jersey, four; Massachusetts, three; and Pennsylvania and Illinois, two each.

And now on request of the American Academy of Pediatrics and the APHA a national clearing house for poison control centers has been established within the Accident Prevention Program, Division of Special Health Services, Bureau of State Services, U. S. Public Health Service.

NEWS FROM WASHINGTON

A Status Report on Health and Medical Legislation at Midterm

At midterm in the first session of the 85th Congress, plans are underway for increased activity on health and medical proposals. The next several months should see a number of measures either enacted into law or considerably advanced along the legislative trail. Bills not enacted at adjournment time this summer will carry over until next January. Here is a summary of the situation:

HEAVY APPROPRIATIONS

The administration's fiscal 1958 appropriation (HR6287) is still before a Senate Appropriations subcommittee, after getting through the House with fewer cuts than any federal agency budget thus far considered. The Senate group was asked by the administration to restore about 80 per cent of the House reductions. Medical research grants were untouched.

DOCTOR DRAFT

Hearings on the bill, HR6548, begin in May. The bill, before House Armed Services Committee, would allow the six year old doctor draft to expire July 1 and amend the regular draft act to permit the selective call-up of physicians, dentists, and allied specialists under the latter law. The American Medical Association is due to testify.

BARBITURATES AND AMPHETAMINES

Bills setting up controls over the manufacture, processing and distribution of these drugs (HR503, 504, and 2498) are the subject of current hearings of a House Interstate health subcommittee. They started April 18 and resume in early May. The AMA is scheduled to provide an expert witness.

TRAFFIC SAFETY

A House Interstate subcommittee has held extensive hearings on what needs to be done to cut down on highway accidents and fatalities. The AMA is expected to be heard some time following resumption of hearing. No specific bill is before the group. In the Senate, the Labor and Public Welfare Committee has pending S1292, but no hearing plans.

CIVIL AIR SURGEON

A subcommittee of the Senate Interstate Committee has held hearings and still has pending a bill (S1045) for a surgeon general for civilian aviation. A similar proposal, HR4275, is before the House Interstate Committee with no indication of hearing dates.

CIVIL DEFENSE

The administration bill (HR4910) increasing the federal role in civil defense has been subject of two days of hearings by a House Armed Services subcommittee. Also, a House Government Operations subcommittee (Holifield) has held hearings on HR2125 and 12 other civil defense bills for a Department of Civil Defense, but has taken no further action.

VETERANS ADMINISTRATION

House Veterans Affairs committee has held hearings on admissions to VA hospitals, including HR58 making statutory and tightening up admission procedures for nonservice-connected cases, but has taken no action. Also pending is HR6719, increasing pay scales for VA doctors, nurses.

MEDICAL SCHOOL GRANTS

Two versions of federal construction grants for medical schools are pending. A Democratic version is S1922 before Labor and Public Welfare; HR6874, the administration bill, is before House Interstate.

DISABILITY FREEZE

The bill (HR6191) extending another year beyond July 1 of this year, the deadline for filing claims under the social security disability freeze law, passed the House March 28 and is pending in Senate Finance Committee.

FEDERAL WORKERS HEALTH INSURANCE

Several versions of federal civilian workers health insurance are pending before House Civil Service Committee: HR6687, 6718, 6832, 7034. Administration bill has not been unveiled.

Democrats Offer Bill for U. S. Aid to Medical Schools

A bill (S1922) for federal aid to medical, dental

for
the first
time

24 HOUR SULFA THERAPY



A single dose of KYNEX provides therapeutic blood levels within the hour. Blood concentration peaks are reached within 2 hours — 10 mg. per cent blood levels persist beyond 24 hours.¹

For greater safety: low dosage, high solubility and slow excretion help avoid crystalluria.

For broad antibacterial effectiveness: KYNEX is particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including *E. coli*, *Aerobacter aerogenes*, *paracolon bacilli*, streptococci, staphylococci, Gram-negative rods, diphtheroids and Gram-

WITH A SINGLE (1 Gm.) DOSE

positive cocci. **For convenience:** the low dosage of 1 Gm. (2 tablets) per day offers optimum convenience and acceptance to patients.

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 Tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

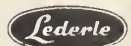
1. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

KYNEX *

SULFAMETHOXYPYRIDAZINE **LEDERLE**

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and osteopathy schools for construction and equipment has been introduced by Democratic Senators Hill, Neely, Humphrey and Smathers. It differs in several respects from the administration bill. Here are some comparisons:

1. The administration bill would amend the present three-year \$30 million a year program for research construction grants by increasing it to a total of \$225 million to be used over the next four years, and for grants to help build teaching as well as research facilities. The Democrats would leave intact the present research grants program of \$30 million a year for three years, and in addition would provide \$60 million a year for five years for teaching facilities, or a total of \$390 million.

2. Under the administration bill, the U. S. contribution could not exceed 50 per cent of the research or teaching project cost. The Democrats also call for 50-50 matching, except that the U. S. would increase its share to two-thirds under two conditions, (a) if the school gives assurances that its freshman class would be increased by 5 per cent, and (b) in the case of new schools.

3. The administration bill would expand the present advisory committee and make it responsible for screening teaching as well as research construction projects, whereas the Democrats would set up a new 12 man committee, with half its members from the medical or dental professions.

Administration Offers its Aid-to-Medical-Schools Bill

Secretary Folsom on April 11 presented to Congress the 1957 version of the Administration's bill for grants to medical, dental, osteopathy and public health schools to assist in building and equipping teaching facilities. Last year the Administration had recommended \$50 million a year in such grants for five years—grants to assist in providing teaching space and equipment. Instead Congress authorized \$30 million a year for three years for grants to institutions, but with the money restricted to medical research facilities and equipment.

The Administration now proposes to add \$15 million to the research fund for the next fiscal year, for a total of \$45 million, to be used to help pay for teaching as well as research buildings and equipment. The following year the total for the combined fund would go up to \$50 million, where it would remain for the next two years.

The revised program would make use of the present 12 member National Advisory Council on Health Research Facilities to review applications. Its name would be changed to include "teaching facilities," four more members would be added, and the commissioner of education would be an ex officio member. The surgeon general of Public Health Service would continue as chairman.

Of the total of \$225 million (this year and next four years) \$30 million would be earmarked for grants to dental schools, with the remaining \$195 million going to medical, public health and osteopathy schools. As under the existing law, sponsors would have to match the federal money 50-50.

In announcing the proposal, Secretary Folsom declared: "We know that the need for medical research scientists, physicians, dentists, and other skilled personnel in the health fields is increasing faster than the capacity of medical schools to train them. The schools cannot increase training in these critical fields without increased facilities. Furthermore, many of the present medical school buildings are more than 50 years old and inadequate for the teaching of modern medicine. In all too many instances, medical and dental schools do not have the financial resources to undertake the necessary construction, rehabilitation, or expansion of their research and teaching facilities.

A temporary grant program will assist these institutions in meeting the health needs of the Nation. Assistance for construction of teaching as well as research buildings is needed to help medical schools train more physicians and more critically needed research scientists. The availability of these funds may encourage the construction of some new medical and dental schools.

Administration Indorses Barbiturates Control Bill

The administration gave its approval April 18 to bills controlling manufacture, distribution and possession of barbiturates and amphetamines. The House Interstate and Foreign Commerce health subcommittee held a one-day session on HR503, 504, 1073, and prepared to hear additional witnesses after the Easter recess. Chairman John Bell Williams said his group would move "with the greatest of care."

Highlights of the hearing: (1) proposals for record keeping and reporting would not apply to the medical profession, (2) cutting down addiction

will require more cooperative arrangements with the States, not just federal efforts, (3) mere "listing" of manufacturers, processors and compounders would not be burdensome, (4) cost of the law during its first year would be \$500,000. Testifying were Rep. Boggs (D-Louisiana) who headed a committee that made an exhaustive study in this field last year, Deputy Food and Drug Commissioner John Harvey and Dr. Kenneth Chapman, consultant to the National Institutes of Health on narcotics addiction. Mr. Williams said the subcommittee wanted to learn whether these particular drugs should be "singled out for special treatment," and whether there are any alternative methods for dealing with the problems.

Pay Increases for VA Doctors Proposed by Rep. Long

To encourage physicians, dentists and nurses to take up careers in Veterans Administration, Rep. George Long (D-Louisiana) in HR6719 proposes increases averaging between 10 and 12 per cent, from the chief medical director on down. The bill also authorizes practice by optometrists in VA facilities. Proposed new scales for an estimated 4,600 physicians in VA are: chief grade, \$13,105 minimum to \$14,200 maximum; senior grade, \$11,820 to \$12,700; intermediate grade, \$10,300 to \$11,500; full grade, \$8,950 to \$9,950; associate grade, \$7,650 to \$8,650, and junior grade, \$7,000 to \$7,400. The measure would affect 785 dentists and 14,850 nurses. The House Veterans Affairs has received testimony from top VA officials that one of their problems is recruitment of professional personnel because of present salary scales.

Tax Bureau Rules on Sums Paid for Volunteer Work

Internal Revenue Service has decided (Rev. Rul. 57-135) that contributions made by hospitals to religious groups in return for free services performed by members are not wages for tax withholding or gross income purposes. Case in point involved a religious committee which assigned young people to duties in mental hospitals and other public institutions. Some of the agencies made contributions to the committee and others did not, but in no instance did the volunteer worker receive any compensation for services performed.

Under these circumstances, IRS held, the hospital is not the employer; hence, it is not liable for taxes under Federal Insurance Contributions Act with reference to sums which it pays to the committee, nor is it obliged to tax-withhold any money.

Annual Report Describes Civil Defense Stockpile

If Health Resources Advisory Committee and its progeny have been taking their time in working up a manpower plan for use in event of a national emergency, the simpler task of stockpiling inanimate necessities for survival has been met with dispatch. Federal Civil Defense Administration last week submitted to Congress an annual report disclosing that \$163 million worth of medical supplies and equipment alone has been bought and warehoused in six year period which ended June 30, 1956. These included more than 26 million doses of vaccines and antitoxins, 7.8 million burn dressings, 201 emergency hospital units, 500,000 doses of atropine and 1.5 million units of plasma and serum albumin.

Announcement should be made soon of details of project which AMA has agreed to undertake for FCDA, involving special studies in one or more selected communities. Unusual feature of this development is its casting of AMA in role of recipient, for first time, of Federal funds on a contractual basis.

Lab and X-ray Technicians Unionized for Higher Pay

Launched recently in Washington, a national campaign is fanning out with objective of organizing laboratory and x-ray technicians in order to obtain higher pay and better working conditions. Office Employees' International Union (AFL-CIO) is parent union of newly established Federation of Technical, Medical Personnel. J. Howard Hicks, secretary-treasurer of OEIU, estimates that 10 per cent of all civilian medical and x-ray technicians in Greater Washington have joined union since its initial organization meeting here on April 1.

Locals will be formed in other metropolitan areas in near future, according to Hicks. New York City, Chicago, Detroit and Los Angeles reportedly are next in line. Aim is not to obliterate or compete with technicians' societies or registries, he told WRMS, but to achieve the salary raises and fringe

benefits which professional groups can not or will not get for members.

"These people are woefully underpaid," he said. "The goal is to bring them the compensation and benefits to which they are entitled by training and the importance of their work. Laboratory and x-ray technicians are being organized first. Later, it is planned to bring in other allied professions, including nurses, perhaps."

Dr. Joseph B. Davis Joins Washington Staff

Dr. Joseph B. Davis, a midwesterner who moved to California, is coming back across the country to join the staff of the AMA's Washington Office. With Dr. William J. Kennard he will maintain contact with the 435 members of the House of Representatives. Dr. Davis received his education at the University of Wisconsin (B.S.), Rush Medical College of the University of Chicago (M.D.), served with the Army in North Africa in World War II, has been in general private practice and has done pharmaceutical research. Dr. and Mrs. Davis have three children.

Washington Chosen as Medical Library Site

When regents of National Library of Medicine assembled in Washington it was to reach unanimous agreement and to make announcement that Greater Washington will continue to be the home of the collection. Ernest Volwiler, one of the regents, gave a report on possible sites in Chicago area. (He is president of Abbott Laboratories, in North Chicago). But when time came to vote, there was no dissent to location of the library's proposed new building on grounds of National Institutes of Health, in suburban Bethesda, Maryland. The site is about 12 miles northwest of the White House.

Funds must still be obtained from Congress for construction of the new plant (planning money only has been appropriated to date). Even if the Illinois delegation in House and Senate discontinues efforts to have collection moved to Chicago, now that regents have acted, delays are in store for this

project. Main obstacle: Reluctance of Administration to ask Congress for building funds, at a time when economy is being stressed, particularly for undertakings which are not in "urgent" class.

\$300 Million in Grants

Senator Lister Hill (D-Alabama) has reintroduced his medical-dental school construction bill in a form only slightly different from his S1323 of last year. It sets up a five year subsidy plan, with \$52 million available annually to colleges of medicine and osteopathy and \$8 million to dental schools. Recipients of grants would have to match U. S. funds dollar for dollar, except that as much as two-thirds of construction costs could be borne by Washington for new schools and established schools which agreed to increase enrollments by five per cent.

Hill bill, which has several Democratic cosponsors, is S1922. Meantime, bills representing Administration's less costly objectives in aiding professional education were filled in House and Senate (HR6874-5 and S-1917).

Holifield and the Blues

Rep. Chet Holifield (D-California) has introduced the bill (HR7034) which Blue Cross, Blue Shield and American Hospital Association hope to see enacted as a vehicle of medical care and hospitalization insurance for some two million Federal workers and at least an equal number of dependents. Employees would be offered wide choice of coverage. U. S. contribution is held to \$2.17 monthly for single employees, \$5.42 for family participants.

National Science Foundation Grants

Following NIH lead in encouraging part-time research by medical students, National Science Foundation in first quarter of 1957 made grants for this purpose to medical schools of Yale, Illinois, Chicago, Emory, Iowa, Harvard, Michigan, Washington (St. L.), Buffalo, Cornell, Syracuse, Hahnemann, Pennsylvania, Tennessee and University of Washington.

LETTERS TO THE EDITOR

Hormones in Treatment of Carcinoma of Breast

Yale University School of Medicine
Department of Surgery
333 Cedar Street
New Haven 11, Connecticut

May 7, 1957

To the Editor:

This letter is being written to you as editor of the CONNECTICUT STATE MEDICAL JOURNAL, so that its contents can be published and hence secure as wide a circulation as possible among the physicians of the State of Connecticut.

I am asking the cooperation of all physicians in this State in an endeavor sponsored by the National Cancer Chemotherapy Service of the National Cancer Institute to evaluate new hormones for the treatment of metastatic and recurrent carcinoma of the female breast. Several new promising drugs have been isolated and preliminary studies are encouraging. Controlled observations, however, are necessary now to determine the full therapeutic value of these medications. This proposed study has already been enthusiastically endorsed by the Cancer Coordinating Committee of the Connecticut State Medical Society.

At this time I am interested in having referred for the study any patient who has had carcinoma of the breast, and who now has symptoms of recurrent or metastatic disease which compels therapy because of advancing symptomatology. Patients to be considered must be (1) naturally postmenopausal at least one year; (2) at least six weeks after any castration procedure (operation or irradiation); and (3) no previous hormone treatment for breast carcinoma (these patients may be accepted at some future time in this study).

At least three centers are planned, at New Haven, Stamford, and Hartford, for examination and evaluation of possible candidates for therapy. These will be conducted once monthly, and a member of the Committee will see new patients and follow each patient accepted for the study. Between visits to the centers, study patients will be managed by their referring physician or the clinic of the referring

hospital depending upon the patients' status. Parenteral medications will be sent to the referring physician in the case of private patients for administration. All costs arising from the study will, of course, be paid by the Committee, except professional fees by private personal physicians.

Connecticut physicians in the past have demonstrated their desire and ability to cooperate in cancer diagnosis and followup. The Tumor Registry in Connecticut is the finest in the country, only because of this cooperation. Another opportunity to further the treatment of this dread disease has been presented to us, and I am sure that we will be able to continue the good work.

Any physician desiring to refer patients for the study may call me collect at New Haven, LOcust 2-1161, ext. 482, and an appointment can be made to see the patient at the center most convenient for her. All physicians referring patients will, of course, be informed of the patient's progress in the event that the physician will not be seeing the patient regularly. More detailed information regarding this study is being furnished to physicians throughout the State in separate letters.

Thank you most sincerely for your assistance.

Sincerely,

Mark A. Hayes, M.D.

Dr. Allman Gets Bar Association Plaque

Dr. David B. Allman, who was inducted this month as president of the AMA, was recently presented with a plaque in recognition of his election to the high office in medicine by the Atlantic County Bar Association. The presentation was made at a dinner in Atlantic City's Haddon Hall. Members of the Atlantic county medical and dental societies were invited to the affair.

At about the same time, Dr. Allman's state medical society paid tribute to him in a resolution, the "resolved" portion of which read:

"That the Medical Society of New Jersey heartily acclaims him for his character and attainments and will ever hold him in prideful and affectionate regard."

The resolution was adopted by the House of Delegates at the state society's 191st annual meeting, which was held in Atlantic City. An appropriately engraved copy of the resolution was presented to Dr. Allman by Society President Lewis C. Fritts.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Paul Winslow Tisher, New Britain
President-Elect, Mrs. Charles Murray Gratz, Cos Cob
First Vice-President, Mrs. Daniel Sampson, Thomaston
Second Vice-President, Mrs. Saul Karpel, New London

Recording Secretary, Mrs. Norman Gardner, East Hampton
Corresponding Secretary, Mrs. Charles N. Sullivan,
 New Britain
Treasurer, Mrs. J. Alfred Wilson, Meriden

Officers 1957 - 1958

Mrs. Barnett Freedman, chairman of the Nominating Committee presented the following slate of officers for 1957-58 which was unanimously elected at the Annual Meeting, May 1, 1957, Hartford Golf Club.

President, Mrs. Paul Winslow Tisher, 389 Shuttle Meadow Road, New Britain; President-Elect, Mrs. Charles Murray Gratz, Cognewaugh, Cos Cob; First Vice President, Mrs. Daniel Sampson, 147 Elm Street, Thomaston; Second Vice President, Mrs. Saul Karpel, 275 Glenwood Avenue, New London; Recording Secretary, Mrs. Norman Gardner, 22 Summit Street, East Hampton; Corresponding Secretary, Mrs. Charles N. Sullivan, 800 Corbin Avenue, New Britain; Treasurer, Mrs. J. Alfred Wilson, 1051 Main Street, Meriden.

ANNUAL REPORT OF THE PRESIDENT-ELECT, 1956-1957

During this year I have attended all board meetings, the School of Instruction at which I conducted the panel for county presidents, and presidents-elect; the National Conference for State Presidents, State Presidents-Elect, and National Committee Chairmen held in Chicago in October, 1956; the annual meeting of the Connecticut Health League; and such other meetings to which I was called.

It was my pleasure to represent our president at the semi-annual meeting of New London County.

As a member of the editorial board of the *Connecticut Quarterly* I have attended numerous meetings pertinent to its publication.

This year, 1956-1957, has been of invaluable help to me as your president-elect. I have been privileged to learn the many facets of our Auxiliary program in detail. Mrs. Hill, our president, has been an excellent teacher and I wish to express my deep appreciation to her.

Respectfully submitted,

(Mrs. Paul Winslow) Dorothy F. Tisher

ANNUAL REPORT OF MEMBERSHIP CHAIRMAN, 1956-1957

In June the membership files were checked with the stencils and corrected. Also membership lists were sent to the

CONNECTICUT STATE MEDICAL JOURNAL office for publication in the annual roster.

Names and addresses of new members and changes of address received from county membership chairmen were sent to Miss Hedges and files corrected.

At the School of Instruction the membership chairmen present were from the counties with the potential membership. The summary was sent to all county chairmen.

Letters and *Quarterlies* were sent to all eligible physician's wives in Tolland County. Two replies were received.

Statistics for the year—Information sent in by county chairmen by March 10 and checked with reports sent in by county treasurers:

COUNTY	PAID				DROPPED NON-	
	MEMBERS	NEW	REINSTATED	RESIGNED	PAYMENT	DEATHS
Fairfield	241	25	0	1	14	2
Hartford	512	41	4	11	2	2
Litchfield	55	2	0	1	1	0
Middlesex	64	4	0	0	0	0
New Haven	180	15	1	7	53	0
New London	120	10	0	1	0	0
Windham	43	2	0	0	1	0
Total	1215	99	5	21	71	4

I wish to thank all county membership chairmen for their time and effort to obtain new members and for helping keep the files and stencils up to date.

Respectfully submitted,

Mrs. Edwin R. Connors

ANNUAL REPORT OF SECOND VICE PRESIDENT AND PROGRAM CHAIRMAN

The program for the School of Instruction held in New Haven on September 10, 1956 included a film on the American Medical Education Foundation.

All Program chairmen who attended the School of Instruction were given the material sent by National. Those who were unable to attend received them by mail.

The Semi-Annual Meeting was held on October 30, 1956 at the Lighthouse Inn in New London. The speaker was Mr. Richard Braisted of Cornell University Medical College who is the Field Representative of Automotive Crash Injury

Research. His topic was "What Auto Crash Injury Research Reveals."

The Annual Meeting was held at the Hartford Golf Club on May 1, 1957. Our speaker was Mr. Thomas A. Hendricks, field director of the American Medical Association discussing "Yardstick for Auxiliary Action."

In March a questionnaire received from National regarding the types of programs given in the State was sent to all the County Program chairmen. When these are received they will be tabulated and sent to National.

Respectfully submitted,
Mrs. Charles Murray Gratz

ANNUAL REPORT OF THE RECORDING SECRETARY

The Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society, composed of seven State Officers, Chairmen of twenty Standing Committees, and seven County Presidents, held four Board meetings: one at the Ram Island Yacht Club in Noank, when the Board members were the guests of the president; one at the Colonial House, Hamden; and two at the Connecticut State Medical Society Building in New Haven. The average attendance was twenty four.

The Eighth Annual School of Instruction was held September 10, 1956 at the New Haven Medical Association Library for all County Officers and Chairmen, with 47 present. The Semi-Annual meeting was held October 30, 1956 at Lighthouse Inn, New London, with 72 members and 9 guests present. The Annual Meeting was held May 1, 1957 at the Hartford Golf Club.

The recording secretary (1) authorized the transfer of funds from the Hartford National Bank and Trust Company, Commerce Branch, New London, to the Home National Bank and Trust Company, Meriden; (2) authorized the new treasurer; (3) attended and recorded the minutes of all meetings held during the year; (4) had minutes of all Board meetings mimeographed; (5) mailed minutes to all Board members; and (6) filed the reports of Officers and Committee Chairmen and the minutes of all meetings.

Respectfully submitted,
Mrs. Norman H. Gardner

ANNUAL REPORT OF THE CORRESPONDING SECRETARY

A list of delegates and alternates to the June, 1956 National Auxiliary Convention was sent to Miss Wolfe.

A copy of the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society for 1956-57 was sent to the executive secretaries of the AMA and the Connecticut State Medical Society.

A directory of State, County officers, standing committees chairman of State and County containing addresses and telephone numbers was compiled, mimeographed, and distributed at the first State Board meeting. An agenda and program for the School of Instruction was prepared with the

president, mimeographed, and sent to all board members and all county chairmen.

Instruction sheets and aids regarding duties of officers and chairman were compiled with the aid of Mrs. L. Roland Hill and distributed at the July 9 Board Meeting and at the School of Instruction.

Stationery was ordered. Supplies were brought to all meetings for distribution.

Mrs. Hill and I met weekly through the year to take care of pertinent business and necessary correspondence.

The notices of the four State Board meetings were sent. The agendas of the Semi-Annual and Annual Meetings were prepared with the president and sent to the printer.

Thirty-three letters of sympathy were written to doctors' wives who had lost their husbands. There were many replies.

Three congratulatory letters were sent to Auxiliary members upon election to office in the State Legislature. They were Mesdames Cook, Vestal, and Shepard.

Respectfully submitted,
Mrs. Saul Karpel

Tribute to Dr. Martha Eliot

The Maternal and Child Health Section of the American Public Health Association, in view of Dr. Eliot's impending retirement as chief of the Children's Bureau, passed a resolution of appreciation of her services at the Section meeting in Atlantic City in November. It reads in part, "she has done an outstanding job in her years of service with the Children's Bureau to promote and develop services for mothers and children. . . . The Section commends Dr. Eliot for the contribution she has made in stimulating and assisting the development of services for mothers and children at State and local levels and for gaining the support of national professional organizations."

THE DOCTOR'S OFFICE

Seymour Lefkowitz, M.D. announces the opening of an office for the practice of medicine and surgery at 808 Highland Avenue, Waterbury.

Joseph A. Manzi, M.D. announces the opening of an office for the general practice of medicine at 58 Broad Street, Middletown.

Paul R. Wohlgenuth, M.D. announces the opening of an office for the practice of plastic and reconstructive surgery at 219 West Main Street, Meriden.

SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL

Middletown, Connecticut

Medical Education Program for June 1957

Monday, June 3, noon

Clinical pathologic conference

Wednesday, June 5, 10:00 A. M.

Tumor conference

Friday, June 7, noon

Grand rounds

Monday, June 10, noon

Frank D. Gray, Jr., M.D., chief, Section Pulmonary Physiology, Yale University School of Medicine

Positive pressure breathing in the treatment of pulmonary disease

Friday, June 14, noon

Grand rounds

Monday, June 17, noon

John McL. Morris, M.D., assistant professor, Department of Gynecology, Yale University School of Medicine

Intersexuality

Friday, June 21, noon

Grand rounds

Monday, June 24, noon

Robert N. Lowman, M.D., associate professor, Department of Radiology, Yale University School of Medicine

The radiologic approach to retroperitoneal tumors

Wednesday, June 26, noon

Gilbert H. Glasser, M.D., chief, Section of Neurology, Yale University School of Medicine

Toxic-metabolic psychotic reactions

Friday, June 28, noon

Grand rounds

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Somerset in Boston, Massachusetts on October 24, 25, 26, 1957.

The Course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, professor of surgery of the University of Minnesota Medical School, who will serve as surgical coordinator and Dr. I. Snapper, director of medical education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical coordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in the Boston area.

The subject matter to be covered in the Course, from a

medical as well as surgical viewpoint, will cover, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gall-bladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

SYMPOSIUM ON INSTRUMENTATION IN MEDICINE

The New England Institute for Medical Research in conjunction with the Foundation for Instrumentation, Education and Research will sponsor a two-day symposium on the need for new instrumentation in medicine and biology. This symposium will be held at the New England Institute for Medical Research in Ridgefield, Connecticut, on June 10 and 11.

The primary invitees to this conference will be physicists, engineers, and instrument designers. Consequently, all the medical and biological problems will be presented in physical, rather than biomedical, terminology.

The primary emphasis will be on those areas for which no instrumentation currently exists. New instrumentation for the following three groups will be considered: (a) research laboratories, (b) analytical and hospital laboratories, (c) the practitioner. Virtually no consideration will be given to classical or established instrumentation. Problems concerned with various disease entities, organ systems, biological phenomena, chemical and metabolic changes, and physical diagnosis will be considered. The subject matter will range from medical problems in man to certain problems in marine biology.

ELEVENTH ANNUAL ROCKY MOUNTAIN CANCER CONFERENCE

Denver, July 10, 11, 1957. Headquarters Hotel Shirley-Savoy. Sponsored by the Colorado State Medical Society and the Colorado Division of the American Cancer Society.

For additional information, write John S. Bouslog, M.D., chairman, Cancer Conference, 835 Republic Building, Denver 2, Colorado.

CONNECTICUT HEALTH LEAGUE

Semi-Annual Meeting 2:30 P. M., Wednesday, June 19, 1957. New Haven Medical Association, 364 Whitney Avenue, New Haven, Connecticut.

"Selling Health Careers."

Moderator: Harvey Olson, Radio Station WDRC, Hartford.

Speakers: William O. Cummings, Life Insurance Management Association, Hartford. C. Russell Sumpf, city editor, *Waterbury Republican-American*, Waterbury. Other speakers to be announced.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1956-1957
(Continued)

REPORT OF THE PRESIDENT

My report will concern some of the perplexing and unresolved problems which are currently plaguing the medical profession in Connecticut and which are likely to influence the future course of medical practice. I already have discussed most of these matters in the President's Page in the *STATE MEDICAL JOURNAL*, but they are important enough to justify restatement for emphasis.

There are few matters which confront the medical profession that are more likely to influence the future course of medical practice than the third party payment health plans. These plans are developing rapidly and they are here to stay unless, or until, medicine becomes socialized. If properly developed and controlled, they will make a lasting contribution toward preserving the present high standard of medical care and hospitalization to which the public is accustomed, and if universally accepted, they can be a powerful bulwark against federalized medicine.

Insurance is the American way of preparing for the unpredictable, and voluntary prepaid health insurance plans will insure the public with better medical care than would be possible under any system of compulsory medicine, providing that they are developed within the framework of private practice. Caution is necessary, however, before giving blanket approval to all plans because some are not without risks to freedom of action by the medical profession and the public. Also, those who control the health insurance plans in this country will determine medical policy, and in some cases the quality of medicine, for large groups of people, and they could eventually control the practice of medicine.

Most third party payment plans have regulations which affect patient-physician relationship, and in this respect it should be of more than passing interest that, at the present time, most of the plans are controlled and organized by sources outside the medical profession. In some, the regulations affect patient-physician relations very little, but in others they deny the public free choice of physician and free choice of hospitals by withholding payments for services unless the services are rendered by a selected panel of physicians or in specified hospitals. It is this last type of plan which poses the greatest threat to freedom of medical action, and which must be opposed vigorously by organized medicine.

Health plans were not developed to restrict medical action or to restrict the public in the choice of physician or hospital. They were developed to preserve the private practice of medicine and to equalize the cost of medical care.

We must examine closely all health plans which affect

medical practice, and we should support those that are for the best interest of community health, and withhold support from those that are not. It is essential for the success of those plans which provide for service benefits, that the third parties, which are placed between the physician and his patient, do not interfere with the customary patient-physician relationship; that the physician who gives service and the public which receives it are satisfied; that the medical profession has a deciding voice in their structure and purpose; and that physicians do not use them as a means for increasing the usual medical fees for service.

Connecticut Blue Cross is one of those health plans which do not cooperate with the medical profession. It has rejected all invitations by representatives of the Connecticut State Medical Council to meet with them and other interested parties for the purpose of discussing the overall problem of medical and hospital insurance plans in Connecticut. Such a meeting between Connecticut Medical Service, Connecticut Hospital Service, the Connecticut Hospital Association and the Connecticut State Medical Society would be in the public interest, and could lead to a joint health program of mutual benefit, second to none in its fairness to everyone and in service to the community.

Connecticut Blue Cross is really a fourth-party plan as far as professional medical services are concerned. The insured pays a premium to Blue Cross, part of which is for medical services. Blue Cross pays the hospital for the medical services which are rendered by a physician. The hospital in turn pays the physician. Such plans which pay hospitals for medical services, instead of physicians, are unrealistic and the Connecticut State Medical Society is on record as opposed to this feature of Connecticut Blue Cross.

Health programs are being sponsored by labor unions in some of the industrial centers because Blue Cross, Blue Shield, and other health insurance plans are not, in themselves, broad enough to satisfy the community need. It is, therefore, difficult to understand why Blue Cross of Connecticut does not recognize that it has a common interest with the medical profession, and why it will not meet with us and other interested groups to discuss this challenge from outside Connecticut.

Although federalized medicine has been rejected by the public as undesirable, the United States Government is, nevertheless, in the practice of medicine on a large scale, not only in the costly Veterans Administration program, but also in the more recent Military Dependents Medical Care Act. This new venture by the United States Government into the field of medical care must be evaluated closely because it is undoubtedly a forerunner of large programs to follow. Medicare, as the Act is commonly known, seems

fair, harmless and generous enough in most respects, and at this stage there is minimal interference with private practice, but things could easily change over a period of years as they did with the Veterans Administration.

In 1917 when the Veterans Administration first authorized purely medical benefits, they were limited to veterans with service connected disabilities. Since that time the Veterans Administration has grown immensely and it has become a powerful political force. It now has 170 hospitals and more than 123,000 constructed hospital beds. For every patient in the Veterans Administration with a service-connected disability there are nearly two patients who do not have service-connected disabilities. The number of hospital beds and the number of patients treated each year have multiplied tremendously in the last two decades. The cost of the program has increased twenty times and the budget today is 825 million dollars.

We don't know and one can't predict what the future holds for Medicare, but we do know—and the Veterans Administration is a good example of it—that big oaks grow from little acorns. We must, therefore, be sure that Medicare develops into a plan which is compatible with private practice. We cannot afford to be indifferent to its development.

Committees studying physician-hospital relations have spent many hours this year and in past years trying to solve, short of legal action, the dilemma pertaining to the practice of medicine by hospitals. Some progress has been made, but the difference of opinion between the Connecticut State Medical Society and the Connecticut Hospital Association regarding the circumstances under which hospitals shall engage physicians to practice medicine, and how physicians shall be paid for practicing it is still unsettled in some hospitals. A solution by agreement seems rather remote because too many physicians who are not hospital employed are indifferent to the circumstances of those who are, and because there is talk in some places that hospitals want State legislatures to pass legislation enabling hospitals to employ all categories of physicians.

Another matter which remains unsolved, and which seems to be getting worse rather than better, is the critical shortage of hospital beds. There are many factors responsible for this, but one of the major causes contributing to the long hospital waiting list is that too many patients who are well and do not need to occupy a bed, enter hospitals for medical investigations which could be done outside the hospital. These patients are walking the corridors, lounging in sun-rooms and sleeping in beds which should be reserved for patients who are in greater need of medical and surgical care. This is happening, not because the medical services cannot be obtained outside a hospital, but because insurance plans will not pay for them unless the beneficiary obtains the services as a patient in a hospital.

The public should be concerned about this because unless the problem is solved, more hospitals will be needed and the public will be asked to contribute toward building them. If hospitals, the medical profession and the public demand it, health insurance plans will be forced to provide payment for diagnostic and therapeutic services regardless of whether the insured receives these services in a hospital or outside a

hospital. Not until this begins can the real need for more hospital beds be determined.

These are only some of the things that are happening which interfere with the private practice of medicine and hospitalization and which menace freedom of medical action. If we wish to resist these things successfully and if we wish to preserve the system of private practice under which medical science has flourished so successfully, every physician must actively participate in their national, state and local medical associations.

The American Medical Association is the national organization which represents all physicians. It has an extensive program devoted to public service and it needs the support of every one of us. There are over 600 physicians in Connecticut who are eligible for membership in the American Medical Association who do not belong to it. If these doctors would reconsider their position and become members so that we had one more than 3,000, we could have another delegate to the AMA. Until we have this other delegate, Connecticut cannot be fully represented in the House of Delegates at the AMA meetings.

The county medical associations are referred to as the grass roots of organized medicine because all actions taken by the state medical associations and by the American Medical Association reflect the thinking which comes from the county organizations. Considering the importance of these county associations in state and national affairs, it is unfortunate that attendance at their meetings does not, with few exceptions, represent a greater proportion of the total membership.

Some physicians do not attend their county meetings because they are not interested in organized medicine. Some do not think they can take the time from their practice and some have other reasons. It is regrettable that this is so, because those doctors who are so busy doing other things that they cannot participate in the affairs of organized medicine, may some day find that the practice of medicine has changed while they were too busy to see the change coming.

While dues are important and necessary, they alone are not enough. Attendance at meetings is equally important and necessary because policy is determined at these meetings by those who attend, and whether it will be determined by a minority, or by a majority of the membership, will depend upon the number of physicians who are present.

Voluntary contributions for the new addition to the State Medical Society building, although not enough to pay for it, have been gratifying and many generous donations have been made. The addition has been finished and the space is now being occupied to advantage. The medical building had to be enlarged because more space was necessary to carry out the functions of the Society. Besides the Council, there are some fifteen standing committees and numerous other special committees which hold meetings in the building, and there is often more than one going on at the same time. These meetings are important and the members of the Council, and of other committees, give considerable time and prolonged study to problems which concern all phases of medical practice. Thus, the membership can give full time to the practice of medicine with the knowledge that their interests are being looked after.

Our executive secretary, Dr. Creighton Barker, is the organizer and coordinator of the affairs and activities of the State Medical Society and without his help and that of his efficient staff, the elected officers and committees could not adequately represent the interests of medicine in Connecticut. We are fortunate to have an executive secretary who is so widely known and respected in the world of organized medicine and who so capably represents the medical profession in Connecticut and carries out its program.

There will be changes in the practice of medicine in the future as there always have been in the past. This is not only good for medicine, it is necessary. Without changes there would be no progress and medicine would stagnate and deteriorate. Since changes are sure to take place, it is necessary to recognize them when they are occurring and to guide and direct them into channels that will preserve freedom of the patient and freedom of the medical profession. Dr. Dwight Murray, president of the American Medical Association, quoted four freedoms from a talk by Dr. Rolf Schloegel of Germany made at the World Medical Association meeting in Havana. Dr. Murray said:

"Our profession does not demand 'unbridled and boundless license without measure or purpose' but it does ask for freedom of choice by patients, freedom in the conduct of medical treatment, freedom of prescription, and freedom from supervision by laymen. These are medicine's four fundamental freedoms as given by Dr. Schloegel. Without them the proper patient-physician relationship cannot be created or maintained and the medical care of the patient cannot be on a private, person-to-person level."

Experience has been that the loss of these freedoms referred to by Dr. Murray is often followed by a lowering of the standards of medical care. It should, therefore, be the purpose of every physician to support all programs that are designed to preserve these freedoms, and to support all physicians, or groups of physicians, who are in danger of losing them. It should also be our determination that the practice of medicine shall remain in the hands of those who are most qualified to preserve the present high standard of medical care.

Ralph T. Ogden

REPORT OF THE CHAIRMAN OF THE COUNCIL

At each meeting of this House, as well as the regular meetings of the Council, I view with wonder and admiration the operation of our various committees. As the printed agenda will show you, there is a multitude of committee reports. It seems appropriate to remind you that these represent the distilled essence of innumerable subcommittee reports, discussions, investigations and compromises.

Reports ranging in size from a half a page to eight or ten pages periodically come to the Council for its approval, suggestion, or amendment. The hours of thought and work and the number of men involved challenge the imagination of one who tries to enumerate them. The stage manager for many of these operations is a man always available but seldom conspicuous. His deft touch can be discerned readily by the initiated. I refer of course to our executive secretary

who receives, catalogues and disperses many of the reports which come to the Council. He is the man responsible for having these agenda compiled and ready for our use.

Recognizing the multiplicity of his duties and responsibilities, the House of Delegates at the Semi-Annual Meeting in 1955 approved the recommendation that the Council attempt to secure the services of an assistant to the executive secretary. A committee for that purpose was appointed at the succeeding meeting of the Council.

To date no suitable candidate for this position has been discovered. This is not surprising in view of the standards to which we have become accustomed. No man is as young as he used to be. Our secretary deserves the assistance of a competent man; one who may learn the many intricacies of this job, under expert tutelage.

Most of you have seen the new addition to the State Society's building. No one can question the wisdom or the thoughtful foresight that went into the planning, construction and decorating of this new unit. Not only does it afford much needed space and a source of additional income but the Barker-Weld room affords the Society the opportunity to honor two of its most distinguished members.

The funds subscribed by members of the Society are somewhat less than the most optimistic prediction but considerably better than the most pessimistic. The treasurer's report will reveal this and show that the Society has suffered no significant financial damage from this enterprise. The committee responsible for this symbol of our vigor and growth deserves deep appreciation.

In the agenda you will find a report of the Committee on Postgraduate Education. Included are the statistics on the meeting in Hartford last December. It will be recalled that the House of Delegates and the Clinical Congress met at the same time with the hope that each might benefit from the other. Though the financial outcome of this venture is somewhat gratifying, the means of achieving it is not so encouraging. The profit was derived primarily from the exhibitors, who for the first time attended this meeting. The work that was done by the committee in arranging such an excellent program deserved better recognition from the members of the Society. I hope each of you will become a missionary in the field to increase the paid attendance at these most interesting and instructive meetings. You are probably aware that for some time the medical and legal professions have been trying to get together to establish a mutually satisfactory code of ethical procedure. Progress has been slow but it seems daylight is ahead. Next week an informal conference between the members of the Bar Association of Hartford County and the members of the Hartford County Medical Association is scheduled with the hope of compromising by personal and friendly discussion some controversial issues. If as anticipated, it serves a useful purpose, similar meetings are to be held in the other counties of the State. Dr. Feeney, the instigator of this enterprise, deserves our sincere gratitude for his efforts.

Probably every practicing physician in the State has at one time or another been subjected to questions and criticisms regarding the polio vaccination program. This program has such wide appeal that the National Foundation, various health departments, and unnumbered lay groups have at-

tempted to direct the course of its activity. As might be imagined this has resulted in all kinds of confusion in the actual implementation of the program. The AMA recognizing this confusion called a conference early this year which was attended by representatives from all the States and Territories, and most of the Health Departments. Out of this came a broad policy which was forwarded to the Council. There, an official policy was formulated which was to act as pattern for the various county associations. This I am sure you have read in the JOURNAL and needs no further explanation. It seems obvious, however, that the success of any program is going to rest with the individual practitioner. He is the only one that can be responsible for the continuity that is necessary to make any program effective.

As I visited the various annual meetings in the counties it became apparent that a large part of the difficulty concerns the fee to be charged for inoculations. Neither the State Society, nor any county association, can possibly establish a fee schedule that is binding on all its members. The determining factor must be the ethical standards of the man who administers the vaccine. It seems incredible that any practitioner of medicine would seek to enhance his income by exploiting a program dedicated to the elimination of a crippling and frequently fatal disease.

On pages 9 and 10 of the agenda you will find printed the report of the Committee on Hospitals approved by this House of Delegates on April 26, 1955. The attempts to implement this resolution have been reported to you on three successive occasions since that time. The subcommittees appointed to achieve this end have changed considerably during these 24 months. The best talent that could be mustered has labored long and diligently in this futile endeavor. Many thousands of words have been printed as committee reports. In the pursuit of a proper solution, many blind alleys have been explored. The blindest of these has been the one that led to Connecticut Blue Cross. It was reported before that an attempt to arrange a meeting between Connecticut Blue Cross and our Society has been met with curt refusal, on the ground that Connecticut Blue Cross and physicians had no common ground for discussion. As mentioned to you last year, there is serious doubt as to whether Connecticut Blue Cross in accepting a premium for service it cannot deliver is acting legally. The Council believes, however, that legality is not its concern but belongs rather to the office of the insurance commissioner.

In contrast to the complete inaccessibility of Blue Cross, the Connecticut Hospital Association has been most cooperative. At a recent meeting between representatives of the Hospital Association and the Council, the most friendly and cooperative feeling prevailed. In spite of differences in points of view, areas of dispute seem minimal and satisfactory compromise assured. It need scarcely be mentioned that Connecticut Medical Service, being so closely integrated with our Society should offer no impediment in the way of complete understanding and cooperation. Because the Council believes the resolution of the Committee on Hospitals approved by this House April 26, 1955 is impossible of satisfactory implementation, it offers the resolution at the bottom of page 8 to be acted on later in this

meeting. I trust that you will give it the most careful thought.

No report at this time could be complete without reference to the loss of one of our most distinguished and beloved members. The passing of Dr. Murdock is too profound an event to appear merely as a portion of the report of the chairman of the Council. Therefore the secretary will present such a resolution at this time.

Respectfully submitted,
C. Louis Fincke

REPORT ON CONNECTICUT MEDICAL SERVICE

The published Annual Report of Connecticut Medical Service for 1956 showed substantial increases in membership, over 1,000,000, premium receipts, claims and reserves. Inasmuch as all Participating Physicians have received a copy of this report, details will be omitted.

However, I would like to comment on the fact that with the conversion of the Standard Contract to the Preferred, there is now a 96.5 per cent of the contracts which are preferred, leaving only a few of the Standard. (These are Union Contracts which expire soon.) The remainder are on Lower Income and Special Individual Contracts.

And this fact ties in with the number of Participating Physicians. During the year, there were a few resignations due to some misunderstanding on the Conversion Program, but many rejoined and now there are 2,805 Participating Physicians as of April 9, 1957. I am sure that the increase is due to the satisfaction of the Physicians with Connecticut Medical Service.

The Professional Policy Committee discussed and endorsed:

A—An Inhospital Medical rider, which provides coverage for the first three days on Inhospital Medical Care, on a \$15 for the first day, \$10 for the second day, and \$5 for the third day basis. This rider will meet the existing needs of the physicians and the Connecticut Medical Service members.

B—Executive Endorsement which allows 25 per cent, 50 per cent and 100 per cent additional indemnity to executives of Connecticut Medical Service Participating Firms.

C—Extension of Surgical Benefits for oral surgeons. The benefits of twelve surgical procedures were added to those which could be done by Participating oral surgeons. From our statistical analyses, these procedures have been done nearly 100 per cent by oral surgeons and not general surgeons. This gives added coverage to our subscribers.

During the first seven years of Connecticut Medical Service, Inc., the greater part of the meetings of the Committee had to do with settling of claims which came in for special consideration. Now most claims can be adjusted by the personnel of the Corporation, due to the fact there are on files, previous decisions on similar claims. But in the past year, more and more of our time was spent in reviewing and digesting a statistical analysis of the utilization of different procedures. The analyses are very revealing, and point out dramatically the abuses which are going on. It is the duty of the Committee to try and correct the abuses. This

has made it obligatory to refer some of the most flagrant cases to the respective counties for appropriate action.

This coming year of 1957 will be the last year of the makeup of the Professional Policy Committee as it is made up at the present time. The next Professional Policy Committee will be made up of twelve members, four of whom will be nominated by the County Society and elected by referendum by the Participating Physicians, and the other eight members will be nominated by the Council of the State Medical Society. The chairman will be nominated by the President of Connecticut Medical Service, Inc. from the twelve. These changes are in accordance with the recommendations of the Committee on Third Party Payments, and accepted by the House of Delegates at its Semi-Annual Meeting last December.

There are many problems yet to face and settle, and I am sure that the Professional Policy Committees of the present and future will settle these problems to the satisfaction of Connecticut Medical Service, Inc., the Participating Physicians, and the people of the State of Connecticut.

Henry A. Archambault

REPORT OF THE DELEGATES TO THE COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

The Fall Meeting of the Council of the New England State Medical Societies was held on December 6, 1956 in conjunction with the Clinical Congress of the Connecticut State Medical Society. No individual program was planned for the Council Meeting since it was hoped that Council delegates would attend the sessions of the Clinical Congress and have the opportunity to hear General Robinson of the Medicare Program and Dr. Dwight Murray, president of the American Medical Association, who were on the Clinical Congress program.

At the Business Meeting a satisfactory financial report was received and it was voted to provide financial support for the Rural Health Conference to be held in New Hampshire during April, 1957.

Since the meeting of the Council we have been informed that the New Hampshire Medical Society has discontinued its financial support of the Council. It appears that a serious question exists as to whether the Council should continue as an organization. This subject will be discussed at the Spring Meeting of the Council to be held in Boston during May.

While it is true that the Council does not have any important matters under consideration at the present time, the fact that it is a formal organization of all medical societies in New England makes it an extremely valuable means of communication and it would seem desirable that it be maintained on a stand-by status for use in dealing with future problems on an area-wide basis.

William H. Horton

REPORT OF THE COMMITTEE ON POSTGRADUATE EDUCATION

Arthur Ebbert, Jr., Chairman

- Gray Carter
Malcolm M. Ellison
Martin E. Gordon
William J. Lahey
John C. Leonard
- Howard Levine
Marvin Lillian
Robert M. Lowman
Morris P. Pitcock
A. Roeke Robertson
Charles Russman

As in previous years, this committee has confined its activities to the planning and arranging of the annual Connecticut Clinical Congress. With approval of the Society's Council, arrangements were made for the 1956 Clinical Congress to be held in December at the Statler Hotel in Hartford. This move from the Yale School of Medicine to the Hartford location was necessitated by the shift from the previous mid-September date to December which conflicted with the school calendar.

The thirty-first annual Clinical Congress accordingly was held on Wednesday and Thursday, December 5 and 6, 1956, at the Statler Hotel. Comparative registration figures for 1955 and 1956 are shown below:

YEAR	PAID REGISTRATION	TOTAL REGISTRATION
	(MEMBERS OF THE SOCIETY AND OTHER PRACTICING PHYSICIANS)	(INCLUDES INTERNS, RESIDENTS, AND MEDICAL STUDENTS)
1955	376	691
1956	446	611

Although there was a decrease in total registration, the registration by members of the Society and other practicing physicians (paid registration) showed an increase of almost 20 per cent. Registration fee was increased from three to five dollars and additional income was derived from ten technical exhibits. It should be noted that this Congress realized a profit of over \$500 and was the first since 1952 to have income in excess of expenses. This good fortune was due to the additional income from exhibits.

Encouraged by the response to the 1956 Clinical Congress, this committee recommended that a Congress be held in November or December of 1957; this was approved by your Council at their January meeting. In order to make the sessions more accessible to physicians in the southern part of the state, Bridgeport was considered as a possible site for the 1957 Congress; however, the available facilities were found to be inadequate. It was then decided that the Congress would again be held in Hartford at the Hotel Statler. Dates of December 11 and 12 were selected so as to avoid conflict with the 1957 AMA Clinical Meeting to be held in Philadelphia December 3-6. The committee is proceeding with arrangements for this thirty-second Clinical Congress with hope of developing an interesting and attractive program.

The committee has found time to discuss other activities in the field of postgraduate education by which it may be of further service to members of the Society. Although no plans for additional activities have been formulated, these discussions will be extended. The committee is currently

of the opinion that there are abundant opportunities for postgraduate (continuation) education available to the physicians of Connecticut but that there is inadequate communication to the physicians regarding the opportunities which are available.

Respectfully submitted,
Arthur Elbert, Jr.

REPORT OF COMMITTEE ON HONORARY MEMBERS AND DEGREES

George H. Gildersleeve, Chairman

H. M. Marvin

Oliver L. Stringfield

The Committee recommends that Emily D. Barringer, M.D., New Canaan, be made an Honorary Member of the Society by the House of Delegates at its annual meeting on April 30.

Dr. Barringer was born in 1876 and received her M.D. degree from Cornell in 1901. She is a Fellow of the American College of Surgeons. The widow of Dr. Benjamin P. Barringer, distinguished urologist in New York, Dr. Barringer is the only woman to have served in the House of Delegates of the American Association and was almost single handedly responsible for the enactment of laws that would permit the commissioning of women physicians as Officers in the Army and Navy Medical Corps.

Respectfully submitted,
George H. Gildersleeve

REPORT OF THE COMMITTEE ON HOSPITALS

George H. Gildersleeve, Chairman

Arthur J. Adams

Herbert Levine

M. David Deren

Bernard F. Mann

William A. Goodrich

Charles T. Schechtman

Vincent A. Gorman

Michael S. Shea

Frederick B. Hartman

Alfred B. Sundquist

Hiram Sibley

The Committee on Hospitals has held four meetings during the past year. Three of these meetings were joint conferences with the Council on Professional Relations of the Connecticut Hospital Association.

At these joint meetings discussions have taken place on the educational permit program permitting the use of graduates of unapproved foreign medical schools as interns or residents, postgraduate education for general practitioners, professional activity study as aid to Medical Staff Records Committees, and further conferences on the Joint Commission on Accreditation of Hospitals as well as a discussion on the report of the Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals.

From these joint meetings originated the idea of conferences between representative staff groups such as Chiefs of Staffs or Medical Staff Presidents and Administrators. Such an experimental meeting has already been held at the Waterbury Hospital. This conference was highly successful and more are planned in the near future. Such discussions should lead to better interhospital relationships.

As a result of a request from the Committee on Hos-

pitals, the CONNECTICUT STATE MEDICAL JOURNAL has published several articles concerning the Joint Commission on Accreditation of Hospitals.

At several of the meetings a guest speaker has helped to crystallize the problem under discussion. At one meeting Dr. Arthur Elbert, Jr. from the Yale School of Medicine was present and discussed postgraduate medical education. At another meeting Mr. Griffith, a representative from the Commission of Professional and Hospital Activities in Ann Arbor, Michigan, described a method utilized by many hospitals for their professional activity studies.

At a special meeting in July the Committee on Hospitals met with Dr. Paul S. Phelps, Director, Tuberculosis Commission, in order to discuss the tentative plan of utilizing vacant tuberculosis hospital beds at Uncas-on-Thames for State Welfare cases with chronic diseases. The committee unanimously voted in favor of this plan.

The joint meetings have proven very worth while and have been exceptionally well attended. I feel that through these discussions there has developed a better understanding between the two committees, and I hope that soon many more of the important problems confronting both groups can be mutually solved.

Respectfully submitted,
George H. Gildersleeve

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

John F. Kilgus, Jr., Chairman

Fred A. Anderson

William Lee

Preston N. Barton

Daniel F. Levy

Norton Canfield

Mervyn H. Little

Roland Z. Carignan

A. Duncan MacDougall

Clement C. Clarke

J. Wister Meigs

John Donnelly

Israel S. Otis

Richard J. Hinchey

Norman Righthand

Andrew J. Jackson

William M. Stahl, Jr.

J. Howard Johnston

Joseph J. Stapor

Benjamin Katzin

Ellwood C. Weise

Thomas F. V. LaPorte

C. Frederick Yeager

The Committee held its first meeting on May 23 1956. The Committee for this year is composed of 23 members, 10 of whom were serving for the first time.

It is of interest to note that the composition of the Committee. Eight specialty fields are represented. Namely, industrial medicine, surgery, internal medicine, dermatology, otolaryngology, ophthalmology, psychiatry, and general practice.

This broad representation of the specialty fields has been a great asset to the Committee in attempting to solve various problems presented to it.

As in the past several years, the Committee was divided into sub-committees. An executive committee composed of the Committee chairman, secretary, and the chairman of the various sub-committees. A specialist sub-committee, composed of men representing seven of the specialty fields. A workmen's compensation sub-committee, a program and

education sub-committee, rural occupational health sub-committee, and a sub-committee on County industrial medical committees.

The Executive Committee has the responsibility of applying and carrying on the work of the committee between the regularly scheduled meetings.

Members of the Specialist Committee advise the committee on problems related to their field and frequently give short talks on their specialty field at the regular committee meetings.

Program and Education Committee has for its chief concern the supplying of speakers and general information on Industrial Medicine to various medical groups throughout the state.

The Rural Occupational Committee is interested in the problem of the various occupations carried on in the rural areas.

The Sub-committee on County Industrial Medical Committees serves as a liaison between the State Committee on Industrial Health and the various county committees on industrial health.

The Workmen's Compensation Committee as its name implies is interested in the many problems concerned with the compensation laws. This committee has a particularly great responsibility during the time the State legislature is in session.

Some time ago the Committee drew up a "Code of Ethics Relating to Occupational Medicine." This was approved by the State Medical Society, the State Medical Society's Council and House of Delegates. It was the plan of the committee to have this published in booklet form and distributed to all the physicians in the state and to representatives of industry and labor. This was postponed however, as it seemed likely that the council on occupational health of the AMA was contemplating some changes in its "Guiding Principles of Occupational Medicine." This project will be carried out, however, as soon as the situation has been stabilized.

One of the questions presented to the Committee during the past year was the matter of whether or not it was the proper function of the industrial physician to administer poliomyelitis vaccine to his company's employees. After long and careful deliberation the committee went on record as being of the opinion that "that the immunization against poliomyelitis was not a function of a physician practicing occupational medicine under the provisions of the Code of Ethics relating to Occupational Medicine." It was further felt that except in the case of impending epidemic or some other unusual situation, the administration of polio vaccine was best left in the hands of the employees' personal physician.

It was again the privilege of this committee to nominate a physician to receive the award of the Governor's Committee on Employment of the Physically Handicapped. The names of several physicians were submitted and a record of their contributions to the employment of the physically handicapped was carefully studied by the committee. After due deliberation the Committee voted to nominate Dr. Dennis S. O'Connor of New Haven as the physician having con-

tributed the most during the past year to the employment of the physically handicapped. This nomination was sent to the Council which acted upon it favorably and the name of Dr. Dennis O'Connor was presented to the chairman of the Governor's Committee for Employment of the Physically Handicapped.

As this report goes to press the Executive Committee and the subcommittee on Workmen's Compensation is busy studying various bills now before the State legislature which in any way pertain to the field of occupational medicine. A critique on all pertinent bills will be prepared for consideration of the full committee on Industrial Health and with the committee's approval will be presented to the State Medical Society's Committee on Legislation. This function of the Committee on Industrial Health is considered very important and a great many man hours of work go into the preparation of the reports submitted to the legislative committee.

In concluding this report, the Chairman of the Committee on Industrial Health wishes to express his sincere appreciation of the wholehearted cooperation given to him by all the members of the committee and for the assistance and good advice so cheerfully given the committee by Dr. Barker's staff and the Council.

Respectfully submitted,
John F. Kilgus, Jr.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE CONNECTICUT MEDICAL EXAMINING BOARD FOR THE CALENDAR YEAR 1956

John D. Booth, President

John H. Bumstead

Louis P. Hastings

C. Louis Fineke

Carl E. Johnson

Creighton Barker, Secretary to the Board

The Connecticut Medical Examining Board is the Society's Committee on Medical Education and Licensure and this report of the Committee is the official report of the Medical Examining Board.

The membership of the Board continues as before. Governor Ribicoff reappointed C. Louis Fineke for the term of five years commencing January 1, 1957.

The Board held six regular meetings during 1956 as required by the Medical Practice Act and one special meeting. Charges were brought by the State Department of Health against one physician for failure to keep a record of narcotic drugs received by him or a record of all such drugs administered, dispensed or professionally used by him, and a hearing was held by the Board, resulting in an official reprimand and warning being given to the respondent physician.

Two hundred and ninety-nine persons were certified as eligible for licensure. The methods of obtaining such certifications were as follows: one hundred and ninety-five presented certificates issued by the National Board of Medical Examiners; sixty-four presented acceptable licenses

issued by nineteen states and forty were certified on the basis of written examination. Sixty-seven individuals took the licensing examinations seventy-nine times. Forty of these candidates were successful and thirty-nine of the seventy-nine examinations failed.

The states from which credentials were presented were: New York 21; Ohio 7; Maryland 5; Pennsylvania 5; Massachusetts 2; Minnesota 2; Illinois 2; California 2; Tennessee 2; Michigan 2; North Carolina 2; Indiana 2; Washington 1; Missouri 1; New Jersey 1; West Virginia 1; Virginia 1; Washington, D. C. 1; Georgia 2; Maine 1; Kentucky 1.

One of the candidates, a graduate of an American medical school, failed the examinations twice. Three of the candidates, graduates of three different Canadian medical schools, failed once, each.

Of the sixty-seven candidates, forty-six were graduates of thirty-one medical schools located outside of the United States and Canada. These forty-six individuals took the examinations seventy-nine times. Twenty-four of the candidates finally passed; the remainder failed, a failure rate of 48 per cent. The schools represented and the number of candidates from each were: University of Berne 2; University of Catania 1; University of Edinburgh 3; University of Geneva 1; University of Glasgow 1; University of Havana 1; University of London 1; University of Lausanne 4; University of Madras 1; National University of Ireland, University College Cork 1; National University of Ireland, University College Galway 3; Oxford University 1; Queens University Belfast 1; University of Tehran 1; University of Zurich 2.

The schools that provided the greater number of graduates during 1956 were:

N. Y. Medical College.....	22	University Pennsylvania.....	7
New York University.....	21	Cornell University.....	5
Yale University	20	McGill University	5
Columbia University	15	University of Vermont.....	5
Tufts College	15	University of Buffalo.....	4
Harvard University	13	University of Cincinnati.....	4
State Univ. of N. Y.,		Temple University	4
N. Y. C.	13	Western Reserve Univ.	4
L. I. College of Medicine	11	St. Univ. N. Y. Syracuse.....	4
Georgetown University.....	10		

The number of graduates of Foreign Medical Schools licensed through endorsement of another state license is as follows:

University of Vienna.....	1	St. Johns University	
French Univ. of Beirut.....	2	(China)	2
University of Naples.....	1	Catholic Univ. of Louvain..	1
University of Lausanne.....	1	University of Berne.....	1
University of Budapest.....	1	University of London.....	2
Univ. College of Dublin.....	1	University of Hamburg.....	1

Thirty American schools and eleven Foreign schools were represented by three or less.

The eligibility of graduates of foreign medical schools is an increasing problem to state medical examining boards throughout the country. For its size, Connecticut's experience is probably more pressing than any other state because of its location and economic character. Unlike other states, Connecticut has not barred foreign graduates from becoming

licensed, but this Board has endeavored to establish regulations to assure that foreign graduate physicians admitted to examinations for license to practice medicine here are as well qualified as the graduates of American medical schools.

Connecticut law allows a registered osteopath to appear before the Medical Examining Board and take the examinations in medicine and/or surgery; and if successful in either or both, he is given a full license to practice medicine and/or surgery in addition to osteopathy. No osteopaths availed themselves of this privilege in 1956.

The admission of graduates of unapproved foreign medical schools as interns or residents in Connecticut hospitals has continued under a statutory provision enacted in 1953. The operation of this law has undoubtedly made it possible for Connecticut hospitals to obtain house staff members from the pool of foreign medical graduates that could not have been employed. There seems to be a trend now for Connecticut hospitals to be attractive to more American graduates and lessen the number of foreign trained interns and residents. Eighty new Educational Permits and twenty-seven renewals were issued, making a total of one hundred and seven issued in 1956.

Another interesting development in the foreign medical school graduate situation is the result of the amendment passed by the legislature of 1955. Under this new law, the Board can, controlled by regulations it deems necessary, admit to examinations an unapproved foreign medical school graduate. The controlling regulation is that such a candidate must have had a minimum of three years of supplemental medical training in the United States. Although several such Petitions have been granted and the candidates admitted to examinations, the number is yet too small to draw any conclusion as to what the ultimate evaluation of this kind of medical education may be. Petitions already approved, 52; Petitions pending approval, 19; number of inquiries, 80.

Respectfully submitted,

John D. Booth

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Robert R. Keeney, Chairman

Noah Barysh	Arthur A. Tower
Alfred L. Burgdorf	Edward T. Wakeman
Clarence W. Harwood	William A. Wilson
H. Patterson Harris, Jr.	Joseph M. Wool
Louis P. Hastings	Joseph Hetzel (chm. subcom-
William S. Maurer	mittee on school health)
Leonard Parente	ex officio
Marjorie A. Purnell	Stanley Osborn, State Bd. of
Robert P. Rogers	Health, ex officio
J. Harold Root, Jr.	

The Committee on Public Health has held monthly meetings during the past year and the attendance has been good. The membership on this committee could be changed somewhat to give more overall representation of the profession. The addition of new members yearly should encourage new thoughts and thinking. The subject matter for the meeting has been very stimulating and interesting and required long hours of deliberation.

This committee favors a Second Connecticut Conference on Physicians and Schools for the latter part of this year under the guidance of Dr. Joseph Hetzel, Chairman, of the subcommittee on school health. The first conference held in 1955 was very successful.

The committee also approves the establishment of a Virus Laboratory in the State Board of Health, the establishment of a Poison Information Center in the State Board of Health, and the adoption of an Act Concerning the Labeling of Hazardous Substances.

This Committee established a Subcommittee on the Mentally Retarded Child which has been very active (Noah Barysh, chairman, Robert P. Rogers, Leonard Parente and Edward T. Wakeman) and will submit a separate report of its activities this year.

The Committee continues to show interest in the program of the State Board of Health for Unmarried Mothers and their Babies Born out of Wedlock. There is much to be done in this field and a great service to humanity to be rendered.

I have been very happy to attend the meetings of the new Committee on Eye Care. The problems have been complex and are of vital interest to this society.

The problem of poliomyelitis vaccination has been reviewed monthly and I was honored to represent this society in Chicago in January 1957 at the Meeting on Poliomyelitis Vaccine. Representatives from all states, territorial health officers and members of the AMA reviewed the program and suggested many new phases and facets for use in this year's campaign to eradicate paralytic poliomyelitis by the increased use of the poliomyelitis vaccine. This vaccine is suggested for use on all ages and groups of people. This is a public service program and all members of the profession are encouraged to participate. We must vaccinate everybody regardless of the cost and energy required. There is plenty of vaccine but the public and the profession are slow to put their shoulder to the wheel and do the job. We hope this society will pull out all plugs to encourage all persons in this State to be vaccinated for poliomyelitis this year before the polio season. If we succeed the reward in public opinion will be "heavenly." We must preach that the vaccine is safe, the vaccine will effectively prevent paralytic polio, all persons from birth to an old age must be vaccinated to prevent paralytic polio, all women must be vaccinated (especially in the child bearing age), and it is safe to vaccinate at all times of the year.

Our slogan: "Eradicate polio by vaccination, sanitation and personal hygiene."

Respectfully submitted,
Robert R. Keeney

REPORT OF THE SUB-COMMITTEE ON SCHOOL HEALTH (Sub-Committee, Committee on Public Health)

Joseph L. Hetzel, Chairman

Stanley J. Osborn	Charles C. Wilson
William J. Sanders	Charles A. Murphy
Ira D. Beebe, D.D.S.	Miss Ruth Byler
Leonard Parante	Martha L. Clifford
J. Harold Root, Sr.	James C. Hart
James H. Root, Jr.	Clifford T. Conklin

Early in the year this sub-committee was involved with the Report of the "First Connecticut Conference on Physicians and Schools," which required considerable editorial work. The report was printed through the generosity of the American Academy of Pediatrics. The Report was subsequently mailed to all participants, members of the Academy, school physicians and nurses, directors of health, superintendents and principals of schools.

A statement on "Periodic Examination of School Personnel" presented to the sub-committee by the State Advisory Council on School Health was reviewed and amended. This has since passed the Advisory Council and been sent to school and health personnel with a covering letter signed by the Commissioners of Health and Education.

A large amount of time was spent revising "Educational Qualifications of School Physicians," published by the American Public Health Association. This revision is now before the Advisory School Health Council for acceptance, it is hoped, as the desideratum ultimately to be obtained in the schools of Connecticut. The title of the revision was changed, owing to content, to "Qualifications and Functions of School Medical Advisors."

This sub-committee was of assistance in securing the publication in the State Medical Journal of a list of school physicians in the State.

The resignation from the sub-committee of Dr. Henry Louderbough, Watertown was accepted. A list of four possible replacements was submitted to the Committee on Public Health which selected therefrom Dr. Clifford Conklin, Thomaston, who accepted the appointment.

At one meeting Dr. Louis Spekter explained the School Evaluation Program instituted by the National Secondary School Administrators Association for the total improvement of schools. There is real value in these evaluations both to the schools and to the evaluators. These studies are now being requested at about one a week. The Department of Health has great difficulty supplying physicians from its own staff to assist in these evaluations. The assistance of about 30 volunteer physicians would be welcome. The experience would certainly increase the physician interest in school health, education and services.

The sub-committee is currently at work on plans for the Second Conference on Physicians and Schools sponsored, as was the first, by the Connecticut State Medical Society.

Respectfully submitted,
Joseph L. Hetzel

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Chairman

Harold A. Bergendahl	D. Olan Meeker
James C. Canniff	James H. Root, Jr.
Harry C. Knight	Stewart P. Seigle
James F. Jones	Mr. William A. Richardson

Strengthening of public and internal information programs by county and local medical associations has been evident during the past year. This has been a valuable contribution to the efforts of this committee in working with component associations to maintain sound relationships. Everything possible is done to augment these local programs and information of statewide interest is directly supervised at the state office.

The importance of physician-patient relationships are accented in a community program because it is closer to the people. The committee has been reminded of this in a number of instances where assistance has been sought for local programming. However, in this private relationship the committee is limited to furnishing such aids as the physician and patient might find of value. Examples of these exist in the Family Health Record and the Emergency Medical Card, also in publications of value to office secretaries and nurses.

More direct services can be performed in the relationships of medical associations with community groups. A major example of this type of activity has been the development of the seven point community service program, "Main Street Frontier" published several years ago as a guide for local planning and which is currently being revised.

Communications with medical association officers and public relations committees at local levels has been a chief concern. To help meet this need the state committee now has a membership which includes all the chairmen of the public relations committees of the component county medical associations. At each meeting, county chairmen exchange experiences and present problems for which they desire counseling or direct assistance. These meetings are supplemented with field meetings in those counties where help has been requested to develop a program based on local needs.

The number of projects with which the committee has become concerned are listed as follows:

Newspaper Releases—Newspaper releases concerning Society activities continue to be transmitted by mail or wire to Connecticut's 25 daily newspapers and 61 weekly newspapers at a rate of 30 to 40 annually.

Radio and Television Releases—All radio stations receive news releases. Television releases have been used with increasing frequency. These require special photographs and advance arrangement with each station to assure their use.

Editorial Releases—These releases contain more information than news accounts. They are accompanied by the report or publication which furnished the facts in the news story. Editorialists are thus invited to explore the original material for whatever editorial comment they may wish to publish.

Connecticut State Medical Journal—Approximately three pages concerning community programs of local medical associations and activities at state and national levels are prepared for each issue of the CONNECTICUT STATE MEDICAL JOURNAL. A special page is prepared each month to present a single message in a manner different from the usual written article. The page has been devoted to campaigns of the American Medical Education Foundation, the issue of free enterprise versus government control, publications available for physicians' reception rooms, exhibits for local medical association use and other projects. Independent articles are also prepared for JOURNAL publication.

Other Publications—News releases and special articles are also prepared for other publications including the *Journal of the American Medical Association*, *Connecticut Pharmacist*, *Bulletin of the Connecticut State Health Department*,

the *Connecticut Quarterly* of the Woman's Auxiliary to the State Medical Society and other organization publications.

Distribution of Publications—The increasing number of health publications and publications for physicians other than professional journals constitutes a growing service. Many more requests are received for this material than a few years ago.

In addition to mail distribution, physicians and others who visit the building often express interest in obtaining certain publications. Therefore a new distribution rack has been installed in the main corridor and has proved highly useful. In addition to publications obtained from the American Medical Association and other sources, several of the Society's own publications are also available.

Family Health Record—This 16-page record has been further distributed during the year to physicians and community groups. It has continued to meet with a favorable response and sample copies have been mailed to all physicians in Fairfield, Hartford, Middlesex and Litchfield counties, with plans now underway for distribution in other counties.

Upon request of the AMA Council on Rural Health sample copies of the record were furnished and later an article about the project was published in the *Journal A. M. A.* As a result, inquiries about the record have been received from medical associations, other organizations and individuals in almost all states and several foreign countries.

Emergency Medical Card—This card was in process of development at the time of the committee's report last year. It has now been distributed to a limited extent for testing purposes and has received a high degree of acceptance. The card is designed as a personal record of medical information which might affect emergency treatment. It can replace the usual identification card and should prove of value to the attending physician who is called upon to care for a patient involved in an accident away from home. The card is intended to be filled out at the time of a physical examination.

Exhibits—Exhibits have been designed for display in connection with the emergency call plans and these have proved effective when used in hospitals, at health fairs and in bank lobbies throughout the state. A leaflet concerning the plans is available with the exhibits and these have also been made available to local medical associations. Exhibits of this type also have been prepared for country fairs and state or national meetings on a variety of medical association services.

Films—The use of films concerning health and medical care represents a growing avenue of communications with school and community groups. Expansion of this activity is being studied.

Certain educational films of the AMA can be obtained through a film service company in New York. This is a major aid to distribution and perhaps a similar plan can be established with other associations in the northeastern states.

Speaker's Bureau—Activities of the Speaker's Bureau have declined during the past two years and plans for reactivation are being made. The Bureau will operate through respective county associations and a new booklet is now being

prepared to inform community groups about this service.

Emergency Call Plans—A survey of the 18 emergency medical call plans which have been established by local associations is now being conducted. The first eight plans which returned the survey questionnaire reported more than 2,700 emergency calls received in 1956. All plans reported that their operation is supervised by a committee of physicians representing a local medical organization. The survey includes a list of questions pertinent to plan operation and the answer to these will furnish information for a special report when the survey is completed. A new plan added to the network this year is that of the Bristol Medical Society.

Science Fairs—This program involves the activities of 159 high school science clubs organized to further student interest in scientific subjects. These clubs annually hold two science fairs, one for Northern Connecticut and one for Southern Connecticut. The Hartford and Fairfield County Medical Associations are active in working with educators and other groups in advancing these annual projects. A new development in Litchfield County promises early organization of a Northwestern Science Fair in cooperation with this committee and medical associations in that area. This national science program is endorsed by the AMA and state and local associations are urged to give their support.

Connecticut Television Committee for Health Education—Committee membership now includes representatives from 18 statewide health organizations comprising the Connecticut State Medical Society, Connecticut State Department of Health, leading voluntary health organizations and four television stations. The purpose is to provide authentic health programs as a public service and to encourage television station managements to seek the committee's guidance when planning health programs. A new series of 30-minute telecasts is currently being produced by the committee each Saturday, 4:30 to 5:00 P. M., from the studios of WHCT—Channel 18, Hartford.

Medical Education Week—Medical Education Week, first observed last year, was the subject of the second observance from April 21-27. Connecticut's part in the program was planned to include television and radio announcements, newspaper editorials and advertising, and the use of medical journals and organization publications.

Newspaper Health Column—This column continues to be popular with the 61 weekly newspapers in Connecticut. It is planned to maintain regular contact with editors by providing a medical association service which can not be obtained elsewhere.

Country Fairs—Exhibits were managed this year at 15 fairs by local committees of the Woman's Auxiliary. The exhibits and accompanying pamphlets portrayed the value of family health examinations and the advantage of enrollment in Connecticut Medical Service. Sponsorship of the project was by the Rural Health Committee in cooperation with the Public Relations Committee.

Other Activities—Other activities which require attention from time to time include radio transcriptions, public health forums, cooperation in the projects of allied groups, school health programs and legislative information.

The committee appreciates the time and effort devoted by

members of the Society to community projects, television programs, emergency services, health forums and other activities which demonstrate the interest of physicians in people and their communities.

Respectfully submitted,
William G. H. Dobbs

REPORT OF THE CONNECTICUT COMMITTEE FOR THE AMERICAN MEDICAL EDUCATION FOUNDATION

William G. H. Dobbs, Chairman

Milton M. Lieberthal	Orvan W. Hess
Charles E. Jacobson, Jr.	Paul J. Gerity
G. Robert Downie	Marjorie A. Purnell
Louis O. LaBella	Mervyn H. Little

The 1956 Connecticut AMEF Campaign to aid the medical schools brought the highest returns to date, with \$18,665 contributed by 916 physicians and \$2,928 by the Woman's Auxiliary.

The result gave Connecticut sixth place in the national campaign. The five leading states in both the number of contributors and the amount of contributions were California, New York, Minnesota, Illinois and Pennsylvania.

Virtually all of the campaign was conducted by county committees with the cooperation of the state committee and the assistance of the Public Relations Department at the State Medical Society.

The amounts raised in the various county campaigns were as follows: Hartford County took first place, with \$11,736 raised from 633 contributors, while 147 Fairfield County physicians contributed \$2,665 and \$1,549 was contributed by 67 physicians in New Haven County. Other county campaigns produced the following results: Litchfield County, \$850, 27 contributors; Middlesex County, \$775; 19 contributors; Windham County, \$260, 6 contributors; New London County, \$200, 8 contributors and Tolland County \$155, 9 contributors.

The national campaign in 1956 also achieved a new record with \$534,075 in contributions from physicians, a gift of \$225,000 from the American Medical Association, \$216,623 from medical associations and allied organizations and \$90,989 from the Woman's Auxiliary and other groups. The grand total for the national campaign was \$1,072,727.

In recognition of Connecticut's campaign activities, Dr. Charles E. Jacobson, chairman of the AMEF Committee of the Hartford County Medical Association and the chairman of this committee were requested for the third year to participate in the national AMEF planning conference in Chicago last January.

Information concerning the contributions of Connecticut physicians directly to the alumni funds of the medical schools is not yet available. However, it can be noted that in prior years these contributions have more than doubled the AMEF campaign figure. In view of the upswing of contributions in 1956, it is anticipated that the alumni fund total may be even higher than last year, when 1,114 Connecticut physicians contributed \$40,207.

The continuing support of Connecticut physicians in this

national effort to aid the medical schools is again acknowledged with deep appreciation.

Respectfully submitted,
William G. H. Dobbs

REPORT OF THE CANCER COORDINATING COMMITTEE

Allan J. Ryan, Chairman

Malcolm M. Ellison	William Mendelsohn
Matthew H. Griswold	Edward J. Ottenheimer
Mark A. Hayes	Robert Tennant

Vincent J. Vinci

Three regular meetings of the committee were held and they were all well attended. The business contracted during the year is described below:

1. Appointment of a medical advisory committee to the Connecticut Branch of the American Cancer Society.

The resignation of Dr. J. Raymond Glazier was accepted with regret and this vacancy was filled by Dr. Ernest C. Shortliffe. The remainder of the committee was reappointed: Drs. Theodore Evans, Chairman, Alfred L. Burgdorf, Joseph J. Esposito, Rolf E. Katzenstein, Mark A. Hayes, and Francis A. Sutherland.

2. Assisting with arrangements for the State Cancer Conference.

Because of the good attendance at the 1956 Conference, the 1957 State Cancer Conference was held again on March 13, at the Hotel Statler, Hartford. Intra-Oral Cancer was the subject of the meeting.

3. Reorganization of the Cancer Coordinating Committee.

It has been proposed to to the Council of the State Medical Society that the membership of the Cancer Coordinating Committee be reorganized as follows: Chairman, one member from the cancer committee of each general hospital in Connecticut, president of the Connecticut Cancer Society, and a representative from the State Department of Health. It is planned that the committee shall be governed by an Executive Committee designated by the Council, which shall include the chairman, president of the Connecticut Cancer Society, representative of the State Department of Health, and six members selected from the other membership of the Committee. An amendment to the Society's By-Laws providing for this reorganization will be voted on at the House of Delegates meeting on April 30.

4. Cancer registry in Hartford.

Dr. John C. Bailer of the Cancer Division of the State Department of Health is assisting in coordinating cancer data from the various hospitals in Connecticut according to organ sites. At present, cancer of the cervix is being investigated. The question of intra-oral cancer is also being reviewed by Dr. Donald P. Shedd.

5. National project for the study of the effect of steroids on metastatic cancer of the breast.

This committee in cooperation with Dr. Mark A. Hayes, chairman, of the Association of Tumor Clinics, is interested in this national program. All advance cases of breast cancer will be given various steroids and the effect will be recorded. This promises to be a most important study.

6. Cancer detection program.

This list of physician needs constant revision and at the present time, some of the county medical associations do not desire to be responsible for this service. This problem needs further exploration before an adequate solution is derived.

It is with a deep feeling of regret that this committee reports the untimely death of Dr. Ashley W. Oughterson. He was an indefatigable member of the committee and other organizations concerned with cancer problems. He will be sorely missed.

Respectfully submitted,
William Mendelsohn, Secretary

REPORT OF THE COMMITTEE ON PROFESSIONAL RELATIONS

Russell A. Keddy, Chairman

Charles T. Schechtman	Daniel F. Levy
Richard I. Barstow	John W. Suplicki
Christie E. McLeod	William Schneider

Brae Rafferty

The Committee on Professional Relations has met three times during the past year.

Several problems dealing with professional relations were presented to the Committee by some of the county medical societies for study and evaluation. These problems were discussed, some at great length, and the involved parties interviewed in each instance. In the opinion of the Committee a satisfactory solution was reached in each case.

Respectfully submitted,
Russell A. Keddy

REPORT OF THE COMMITTEE ON MENTAL HEALTH

Francis J. Braceland, Chairman

John A. Atchley	Jean de Chabert-Ostland
John H. Bumstead	Franklin S. DuBois
Charles W. Culotta	Foster E. Priddy

G. Gardiner Russell

This is a report of the chairman of the Committee on Mental Health of the Connecticut State Medical Society. This committee has met on several occasions at dinner meeting in Hartford, the last meeting being Thursday, February 21. It is difficult to get the committee members from various parts of the state together but there were five members of the committee present at this last meeting. The Commissioner of Mental Health of the State of Connecticut was an invited guest.

It is probable that the Society has noticed that there has been a let down in activity in this committee ever since the formation of the Department of Mental Health of the State and the formation of the Committee on Mental Health to advise the Governor. One of our members, Dr. Franklin S. DuBois, of New Canaan, is a member of this latter group, and of course members of the Society are in the positions of Commissioner and Assistants.

There are a few pressing problems but they are large ones which require widespread cooperation, so our task has been

considered by us to be one of watching the activities of the various groups and keeping the Society informed of the status of the mental health problem in Connecticut. Our last report to you concerned the 10-point program of the Commissioner of Mental Health and this was approved by the Society.

The problems, as the Committee sees them now, lie in three areas. The most pressing one at the present moment is the status of the budget of the Department of Mental Health. The Governor has expressed his interest in the problems which the Department of Mental Health faces and in his budget message believed that he was giving the Department four million dollars increase. This is not at all sure now, as the budget is examined and scrutinized carefully. Apparently something has happened en route. Under the present budget not only will there be no carrying out of any of the new things suggested by the Commission, but it does appear as though the salaries which are already budgeted for with elevator increases might utilize a great deal of what has been appropriated. This is not at all sure at this writing. Until the Budget Committee meets, it is impossible to make a final decision. It is important for us, as a Society, to keep watch on this situation for the welfare and health of people in mental hospitals will be in jeopardy unless careful attention is paid to all aspects of the problem. I will attempt to make a further report on the situation which will face us as the budget is acted upon finally. It is unwise to pay attention to rumors and therefore I shall simply mention the fact that some of the superintendents feel that their daily food ration of 71 cents per patient is in danger. It must be kept in mind that mental patients have always been the first to suffer when cuts were to be made and it is urgently hoped that this will not continue. These folks are just as sick as anyone in our general hospitals and just as deserving of every consideration.

There is another problem which should be considered by the Society, probably by this Committee, but it is one which will require the assistance of everyone. A short time ago there was widespread hysteria and a Federal law was passed which enabled judges to give men life sentences for drug addiction, particularly for selling drugs. It is granted by this Committee that this is a serious situation and, should anyone be found who is in any way involving the youth of the country in the taking of drugs, he certainly should be punished. The fact is, however, that it is very difficult to separate users from sellers and many times a man sells drugs simply in order to insure his own supply. Each case is an individual one and each one should be considered separately. It is respectfully suggested to the Society that this is as much a medical problem as a legal problem, even more so. Men are required to be sellers because they cannot procure the drug except at exorbitant rates from someone else. This makes for a vicious cycle. If it were possible for these folks to be treated and the supply was under careful medical or legal control, much of this trouble would disappear. As it is, the addict must resort to bootleggers and to do so furtively.

There is also feeling about that drug addiction is the basis of crime. This is not borne out. It is true that it does lead to larceny and in the female perhaps involve prostitution in order to get funds to buy the drug. But in most part the

person who is under drugs does not commit a major crime. He wants to be comfortable and to be left alone. The social aspects of this are realized. It is known that the public must be protected; certainly the youth of the country must be protected. But there are other ways of doing this than the imposition of life sentences. It is therefore suggested that a study be made of this problem, a study which would involve the medical, legal, psychiatric professions; that help be secured from interested citizens and attorneys; and that some effort be made to solve this problem. The British apparently do a much better job than we do at this time with this problem.

There is another situation which is worthy of the attention of the Society. Despite the obvious advantages of having psychiatric wards in general hospitals, there are only three such wards out of 33 Connecticut hospitals. If we are to make any inroads on the problem of mental disease, then we must have the cooperation of general hospitals and the practitioners of medicine in all disciplines. People are willing to send patients with mental illness to general hospitals, when they are not willing to put them in mental hospitals. Also, if provision is made, it is possible to catch some of the illnesses early and thus prevent great difficulty later on.

Another advantage in having psychiatric beds in a general hospital is that it will break down the wall which now exists between psychiatric and other illnesses. Most important of all, it will involve the general practitioner and the men from other disciplines in the treatment of this illness. Until we get to the point where the practitioners are interested, even willing, to make rounds on their patients in mental hospitals like they do in general hospitals, we will not have made a satisfactory step forward. It is true that there are great demands on the beds for other ills, but it is also true that these patients are just as needful of attention as are the various other chronic illnesses. It is recognized and admitted that, when an acute situation obtains, that should get attention first, whether the problem be surgical or medical. We have no desire to blow this problem up out of its proper proportion nor is it our feeling that general hospitals should in any way become mental hospitals. But for the welfare of all concerned it would be to the advantage of the various institutions to have beds set aside in which patients could be treated early and thus catch the diseases in their incipency and prevent the patients from coming to a final repository because people are unwilling to do something about it early.

This is a serious problem which requires the cooperation of everyone. It has interested this Committee for several years and various members of the Committee made appeals to hospitals which were enlarging their buildings or constructing new facilities. Thus far we have met with little success.

With this report the chairman respectfully thanks the members of the Committee for their willingness to cooperate, and particularly thanks Dr. Creighton Barker, the secretary, for his interest, help, understanding and complete cooperation, and thanks the Society for their patience and forbearance. This is an important committee and its work is not done.

Respectfully,
Francis J. Braceland

REPORT OF THE COMMITTEE ON THIRD PARTY PAYMENTS

William H. Curley, Jr., Chairman

Donald G. Arnault
Frank H. D'Andrea

Christopher E. Dwyer
Benjamin V. White

Since the report of this committee to the House of Delegates on December 6, 1956 the following events have transpired. On December 20, 1956, the Council of the Connecticut State Medical Society voted that this Committee be designated the committee of the Connecticut State Medical Society to which the professional policy committee of Connecticut Medical Service could refer any contemplated changes in the Connecticut Medical Service Contract for comment.

As of March 1, 1957, this committee has received one communication from the Connecticut Medical Service, Inc. On January 29, 1957, this committee was notified that the professional policy committee of CMS had voted to recommend to the Board of Directors of CMS adoption of the recommendations contained in this committee's report to the House of Delegates in December 6, 1956. The Professional Policy Committee further felt that designation of this committee as a liaison between the Connecticut State Medical Society and CMS was "an excellent procedure." As of March 1, 1957, no request for action by this committee has been received from the Professional Policy Committee of CMS.

The one task remaining to us by action of the House of Delegates on April 24, 1956, is to prepare "a statement of policy for guidance of the members of the Society in meeting the problems of third party payments." This Committee must beg the indulgence of the House of Delegates for more time in preparing such a statement. The field of third party payments is constantly changing. Each area of third party payments seems to produce problems peculiar unto itself. The code of ethics of the AMA is at present under revision. Several proposals have been put in writing by this committee but at present we have not been able to agree on such a statement of policy.

Respectfully submitted,
William H. Curley, Jr.

REPORT OF THE COMMITTEE ON EYE CARE

Clement C. Clarke, Chairman

Max Alpert
Morton Arnold
Alfred L. Burgdorf
Merrill Grayson
Louis D. Harris
Joseph L. Hetzel
N. William Humpage

Robert R. Keeney, Jr.
John F. Kilgus, Jr.
Milton F. Little
J. Miles O'Brien
John P. Simses
Arthur C. Unsworth
Frederick A. Wies

The most important event in this committee's activities during the past year was its creation.

First, the ophthalmologists of the state felt they should participate more actively in the problems facing the State Medical Society, specifically those dealing with the many aspects of eye care.

Second, a channel for bringing eye care problems before the whole State Medical Society was needed. Consequently

the EENT Section submitted a resolution to the Council that a Committee on Eye Care be set up. Through action of the Council and the House of Delegates between November 1955 and April 1956 the By-Laws were amended and this Committee came into being.

The Committee has tried to justify its existence. It has held 6 meetings, each lasting for 3-5 hours. Numerous questions relating to Eye Care were referred by the executive office of the State Medical Society to this Committee for action or for consideration and recommendation.

The Committee aided in the final development of a form to be used in schools for vision screening and issued jointly by State Board of Education and State Department of Health. This form and the general policies for giving vision tests in schools was presented to and approved by the State Medical Society and was published in the *CONNECTICUT STATE MEDICAL JOURNAL*, February 1957.

Closer cooperation with another state agency, the State Board of Education for the Blind, has been another objective. A special dinner meeting of the Committee was turned over to Mr. Sherberg, the executive secretary of that Board. It is hoped that the people of the state will benefit by a more active coordination of welfare and ophthalmology.

This Committee has endeavored to establish good liaison within medical circles by including the officers and the members of the Executive Committee of the EENT Section in its membership, by exchanging representation on other state society committees, e.g., Industrial Health, Accident Prevention, Legislation, School Health, Public Health, and by including representatives of the National Medical Foundation of Eye Care and the National Society for the Prevention of Blindness among its members.

Legislatively, the Committee serves in an advisory capacity on many bills which deal with visual requirements and other eye problems. The aggressive legislative program for extension of the privileges of the optometrists will require careful scrutiny by the whole Society as well as this Committee just as in the case of naturopaths, osteopaths, and others.

Respectfully submitted,
Clement C. Clarke

REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

Maxwell Lear, Chairman

Howard S. Colwell
Gregory K. Dwyer
Daniel Hardenbergh

Edward Nichols
Allan M. Ross
N. William Wawro

Herewith is the report of the Committee on Cooperation with the Yale School of Medicine. I have been in verbal contact with our good friend, Dean Lippard from time to time. Though no agenda have developed—a testimonial to the fine relationship in this area, we both feel that the activity of the committee should be continued.

I have enjoyed being available in this matter and will be glad to continue if that is required.

Respectfully submitted,
Maxwell Lear

ANNUAL REPORT OF COMMITTEE TO STUDY
MATERNAL MORTALITY AND MORBIDITY

Carl E. Johnson, Chairman

- | | |
|----------------------|---------------------------|
| Eric H. Blank | Hugh K. Miller |
| C. Lee Buxton | Jessie E. Parkinson |
| Lewis P. James | Charles H. Peckham |
| David M. Little, Jr. | A. Roche Robertson |
| Bernard F. Mann, Jr. | W. Leslie Smith |
| Norman C. Margolius | Hoyt C. Taylor |
| Donald J. McCrann | Archibald W. Thomson, Jr. |
| Stanley B. Weld | |

The Committee to Study Maternal Mortality and Morbidity of the Connecticut State Medical Society held five regular meetings during 1956, all of which were well attended.

Three open sessions were held as follows:

- February 14, 1956, Lawrence & Memorial Associated Hospitals, New London.
- March 9, 1956, Middlesex Hospital, Middletown.
- April 14, 1956, Stamford Hospital, Stamford.

At these open meetings the committee attempts to bring to the physicians in the local communities maternal mortality case reports which illustrate some of the factors contributing to maternal deaths in Connecticut. All of these meetings have been well attended and there has been good participation on the part of the local physicians.

The provisional maternal mortality rate for 1956 is 3.4 per 10,000 live births.

Total number of cases of deaths among women who were pregnant reviewed by committee.....	15
Deaths due to non-maternal causes.....	3
Deaths due to maternal causes.....	11
Unclassified deaths	1

SUBCOMMITTEE ON TOXEMIA

The members of this subcommittee are:

Hugh K. Miller, Chairman

- | | |
|------------------------|---------------------|
| Louis C. Backhus | Donald W. Morrison |
| David F. Conway, Jr. | Willard J. Morse |
| Howard S. Eckels | Jessie E. Parkinson |
| Franklin Epstein | Vincent Pepe |
| Morgan V. Flaherty | A. Roche Robertson |
| Grace V. Gorham | Robert Shreve |
| Derick A. January | Edward J. Sokolski |
| Frederick C. LaBrecque | Hoyt C. Taylor |
| John J. Lacava | Roger C. terKuile |
| Bernard F. Mann, Jr. | Julius G. Weiner |
| Luigi Mastroianni | Robert H. Wyatt |

The Subcommittee on Toxemia of the Committee to Study Maternal Mortality and Morbidity of the Connecticut State Medical Society held five regular meetings during 1956, all of which were well attended.

Total number of cases of toxemia reviewed.....	5
Severe cases of toxemia.....	4
Deaths due to toxemia.....	1

In the January 1956 issue of the CONNECTICUT STATE MEDICAL JOURNAL the Committee to Study Maternal Mortality and Morbidity together with the Subcommittee on Toxemia presented a maternal mortality case report which emphasized

the importance of epigastric pain in pregnancy.

In the October 1956 issue of the CONNECTICUT STATE MEDICAL JOURNAL a second case report was presented which emphasized the importance of early recognition of symptoms and adequate treatment in cases of toxemia.

The Subcommittee has prepared a toxemia routine for hospitals and is now in the process of preparing a postpartum routine for patients who had pre-eclampsia during the antepartum or intrapartum period, and a postpartum routine for patients with eclampsia during the antepartum, intrapartum, or postpartum period. These routines will be published in a future issue of the CONNECTICUT STATE MEDICAL JOURNAL and will be added to the manual prepared by the Subcommittee on Minimum Standards for Hospital Care of Maternity Patients.

Two meetings of the Subcommittee on Toxemia were turned over to guest speakers. William K. Bannister, Chairman of the Anesthesiology Study Group in Connecticut, discussed the use of analgesia and anesthesia in pre-eclamptic and eclamptic patients; Franklin Epstein, assistant professor of Medicine at the Yale Medical School, discussed the use of hypotensive agents in toxemia of pregnancy. The material presented at these two meetings was used by the members of the Subcommittee as a guide in preparing their recommendations for the toxemia routines.

SUBCOMMITTEE ON MINIMUM STANDARDS FOR
HOSPITAL CARE OF MATERNITY PATIENTS

The members of this Subcommittee are:

Charles H. Peckham, Chairman

- | | |
|-----------------|---------------------|
| C. Lee Buxton | Lewis P. James |
| Robert C. Emmel | Jessie E. Parkinson |
| Ralph C. Wright | |

The Subcommittee on Minimum Standards for Hospital Care of Maternity Patients had six meetings during 1956 during which a manual entitled "Standards and Recommendations for Hospital Care of Maternity Patients" was prepared. The Subcommittee throughout its meetings had one end in view and only one, the safest possible hospital care of maternity patients from the standpoint of current medical knowledge and present hospital facilities throughout the State. The Subcommittee realizes that the manual is incomplete and it is hoped to add to it as further problems make additions necessary.

The manual, "Standards and Recommendations for Hospital Care of Maternity Patients," was approved by the Committee to Study Maternal Mortality and Morbidity at the meeting on November 14, 1956. The manual was then forwarded to the Bureau of Maternal and Child Hygiene of the Connecticut State Department of Health for approval and use in the maternity hospitals in Connecticut.

It is earnestly hoped by the Subcommittee that its endeavors have resulted in a set of minimum standards for hospital maternity care which will be of some aid to the medical profession, the hospitals of the State, and the Connecticut State Department of Health in the task of constantly seeking for the women of Connecticut the best possible treatment during pregnancy, labor, and childbirth.

Respectfully submitted,
Carl E. Johnson

REPORT OF THE CONFERENCE COMMITTEE WITH THE STATE BAR ASSOCIATION

Thomas M. Feeney, Chairman

John D. Booth

Andrew J. Jackson

Oliver L. Stringfield

During the past year the Conference Committee with the State Bar Association has met frequently and as a result have approved the Principles of Cooperation between the Bar and Medical Profession of the State. The House of Delegates at the December meeting approved these principles.

At the present time the Committee is engaged in setting up a Medico-Legal Seminar. It is hoped that in a meeting of the members of each profession methods can be explored which will lead to increased understanding of mutual problems.

Respectfully submitted,

Thomas M. Feeney

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE CEREBRAL PALSY ASSOCIATION

John F. Paget, Chairman

Cole B. Gibson

Roswell D. Johnson

Thomas F. Hines

Ward J. MacFarland

This is actually a stand-by committee, the purpose of which is to lend guidance to the State Cerebral Palsy Association if needed or requested. There is no new activity to report at the present time.

Respectfully submitted,

John F. Paget

REPORT OF THE COMMITTEE ON ACCIDENT PREVENTION

Louis Spekter, Chairman

Harold A. Bergendahl

Norman H. Gardner

Alfred L. Burgdorf

Stuart L. Joslin

Clement C. Clarke

John F. Kilgus

William M. Stahl, Jr.

The committee on accident prevention was established by the Council of the Connecticut State Medical Society in the spring of 1956. The purpose of the committee was stated as follows: "The purpose of the committee is to study the causes of personal accidents in Connecticut and, in cooperation with the committee on accident prevention of the Connecticut Chapter of the American Academy of Pediatrics and similar committees from other organizations, to make recommendations to prevent accidental injuries among the people of the state."

The members of the committee represent various fields of medicine and public health. In addition, several individuals as members of other committees of the state medical society have special interests in certain phases of accident prevention.

The first meeting of this committee was held on December 12, 1956; monthly meetings have been held since.

Here are some of the items discussed by the committee:

1. Committees of the State Medical Society now engaged in activities in the field of accident prevention.
2. State and local organizations, both official and voluntary, in Connecticut that are concerned with accident prevention.
3. Activities of accident prevention committees of other state and local medical societies.
4. Cooperation with the Connecticut Chapter of the American Academy of Pediatrics on a specific project.
5. Exploration of activities of official and voluntary organizations in Connecticut concerned with accident prevention.

(a) Connecticut Safety Commission. Representatives of this commission met with the committee for discussion, particularly with respect to injury and death resulting from motor vehicle accidents. As a result of this meeting the committee voted to approve legislation introduced by the Connecticut Safety Commission with respect to a Uniform Vehicle Code—Chemical Tests, tests for intoxication. At this meeting was discussed the history of the Connecticut Safety Commission; ratio of injury to deaths from motor vehicle accidents; role of physicians with respect to prevention of motor vehicle accidents; the problem of re-examination of drivers; driver examination of selected groups; legislation on chemical tests for intoxication; the matter of limited licenses; research; surveys on rural and home safety programs which is now being made in Connecticut by the National Safety Council through the Connecticut State Department of Health; driver education in secondary schools.

(b) State motor vehicle department. Six representatives of the state motor vehicle department met with the committee. Plans are being made to meet with representatives of other state agencies to determine the needs as they relate to medical aspects of accident prevention, and how the committee on accident prevention can be of assistance.

The committee recommended for endorsement by the committee on legislation Senate Bill #194—An Act Concerning the Establishment of a State Poison Information Center, and Senate Bill #60—An Act Concerning the Labeling of Hazardous Substances.

6. The committee reviewed material presented in a symposium, "The Medical Aspects of Motor Vehicle Accident Prevention," published in the *New York State Journal of Medicine*, December 15, 1956, Volume 56.

7. The committee touched upon such subjects as the relationships of epilepsy, visual defects, emotional difficulties, etc., as they affect the occurrence of motor vehicle accidents.

As can be seen from the above report the committee is still in the process of exploring what is being done in Connecticut; what is being done elsewhere; what are the needs in Connecticut from the medical point of view.

Respectfully submitted,

Louis Spekter

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**SEARLE**

REPORT OF THE JOINT COMMITTEE OF THE
CONNECTICUT STATE MEDICAL SOCIETY,
CONNECTICUT PHARMACEUTICAL
ASSOCIATION AND THE CONNECTICUT
STATE DENTAL ASSOCIATION

Benjamin Katzin, Chairman

Bradford S. Colwell

Walter J. Keefe

Henry J. Messinger

Fritz M. Meyer

The committee has met four times during the past year and each meeting has been well attended by members of the three participating groups. The function of the committee has been a liaison group, representative of the three professions involved.

The deliberations have been principally concerned with: (1) Legislation, (2) Relations with the Committee on Foods, Drugs, Cosmetics and Devices, (3) Discussion of problems relating to the professional relations between physicians and dentists and pharmacists.

(1) The Hazardous Substance Bill was discussed and the changes in its form were approved. It was the feeling of the committee that this was a sound bill and should be supported by the professions. Recommendations to do so were made to the parent organizations and support of the legislative committees were advised. It was also the consensus of opinion to support the principle that the Connecticut laws on narcotics be made to conform to the Federal regulations.

(2) The Committee on Foods, Drugs, Cosmetics and Devices was originally set up as an advisory sub-committee of this group. It has, however, long since outgrown this status and has desired autonomy. This committee therefore voted to dissolve the former status so as to enable entirely separate functioning of the two committees, still maintaining such contact as would be useful in furthering any overlapping interest. The sub-group has since changed its name and reports directly to the supporting agencies.

(3) Many common problems exist and arise in the day to day contacts of physicians and pharmacists. Numerous opportunities exist to improve the interprofessional relationship between the groups and the committee constantly strives to improve these relationships. This is done by discussion of the problems, recommendations to the sponsoring groups and representation by your chairman at the annual meeting of the State Pharmaceutical Association.

The various groups have shown excellent cooperation and the committee undoubtedly contributes greatly to strengthening the bonds between the participating groups and improving the interprofessional relationship.

Respectfully submitted,
Benjamin Katzin

OUR NEIGHBORS

Maine

The Thayer Hospital in Waterville carries on an intensive course of instruction for laymen conducted by the medical staff of the hospital. The group of fifteen meets once a week at the hospital in an endeavor to obtain a better understanding of medical and hospital affairs.

Massachusetts

Dr. Norman A. Welch, Boston, was re-elected chairman of the Blue Shield Commission at its meeting in San Francisco in March. In his report to the commission, Dr. Welch paid the following tribute to the AMA:

"I think it is of special importance to include in my report significant recognition of the American Medical Association for its outstanding cooperation with the Blue Shield Commission during this past year. The executive staff of the association and its representatives, who serve by appointment on your commission, have contributed immeasurably to the affairs of Blue Shield this year. We are indebted to them for their interest.

"In this regard it is especially important to stress that the physicians participating in the affairs of Blue Shield and in the American Medical Association represent the two largest groups of doctors in the world. They are all dedicated to the preservation of the traditions of American medicine and to the desirability of voluntary health care coverage as an important factor in securing those traditions against the encroachment of compulsory government health care insurance. Locally, our plans and their sponsoring medical societies are, have been, and will continue to serve these aims. I am particularly pleased to add that, nationally, the American Medical Association has extended the warmest degree of cooperation in the interest of the plans and commission. The resolution adopted by the House of Delegates last year represents an expression of the association's confidence in us, and it has served as a source of

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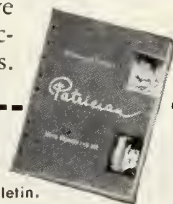
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pride, motivating our plans to greater efforts in continuing the development of Blue Shield in the interest of the medical profession. I am indeed pleased, therefore, to express the gratitude of plans, their sponsoring societies and the Blue Shield physician trustees for the cooperation and support of the American Medical Association and its headquarters staff."

Subjects covered at the Blue Shield conference included: 1. the Medicare program and the part played by the Blue Shield Plans; 2. the enrollment of federal employees in any future health program developed for them and their dependents, and 3. proposed changes in the constitution and by-laws and changes in the make-up of the commission.

As the result of the work of an *ad hoc* committee over a period of three years Harvard Medical School has now come up with a rearrangement of the curriculum for its first two years. In each year the general approach was first, to establish a firm footing in each basic science, and later to apply the

multidiscipline approach to a number of important problems of human biology. Further, the major emphasis in the first year was to be on the normal, and increasing attention would be turned to the abnormal and disease states in the second year. A course called, for lack of a better term, "Growth and Development" is carried through both of the first two years. More free (unscheduled) time is included for elective courses and research work. Finally, an active tutorial system will be provided, the tutors serving as advisers and counsellors, about one for every six students.

Vermont

The University of Vermont College of Medicine is engaged in a new building program which is part of the University's seven million dollar program. The present college of medicine was built in 1829, seven years after its founding, and is now used by other departments of the college. The proposed site of the new College of Medicine adjoins the Mary Fletcher Hospital in Burlington.

AROUND THE STATE

Connecticut Regional Blood Program

	JULY 1, 1956 THROUGH APRIL 30, APRIL 1957	
DONORS	1957	1957
Donors accepted	8,048	73,828
Donors rejected	862	7,776
Donors registered	8,910	81,604
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from Center	6,732	62,065
Blood collected by hospitals.....	542	7,066
To fractionation stock pile.....	234	907
To out of State hospitals.....	108	994
	7,616	71,032
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	80	959
Processed into packed cells.....	2	66
Processed into liquid plasma.....	923	8,177
	1,005	9,202
Discarded — unfit and broken.....	51	557
Grand Total — distribution of blood....	8,672	80,791

Blood returned to Center for processing into plasma and fractions.....	869	7,299
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	54	529
Fresh frozen plasma (125 cc.).....	197	1,839
Serum albumin (100 cc.).....	102	1,646
Immune serum globulin (2 cc.).....	3	3
Packed red cells (bottles).....	2	66
Fibrogen (bottles)	0	8

On May 15 of this year the procedures used in typing blood at the Connecticut Blood Center were changed in accordance with the recommendation of the Connecticut State Medical Advisory Committee. It is anticipated that the changes made will be made mandatory by the National Institutes of Health for all federally licensed blood banks.

The usual grouping and back grouping of the ABO system continues as before. The D factor is specifically tested followed by a screening of the CDE factors. Should this test prove positive, E and C are specifically tested. Furthermore, in all cases of D negative blood an indirect Coombs test is done

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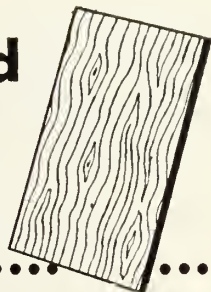
Please send me a copy of the booklet:
"Your Financial Secretary"

Name

Street & No.

City or Town.....

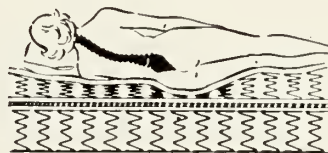
A Bed Board is only half the answer!



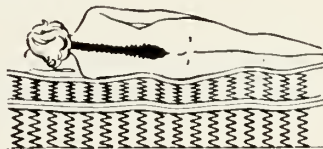
A bed board can only prevent a box spring from sagging; it cannot correct the mattress. Here's why:



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to determine the presence or absence of D variants.

As before, all O blood typed in this Center will continue to be titrated in a 1:200 dilution to separate those bloods which may be dangerous if given to other types due to a high titer of agglutinins.

Code of Cooperation With Bar Association Approved

The code of cooperation for physicians and attorneys devised by the Conference Committee of the State Medical Society with the Connecticut State Bar Association was approved by the House of Delegates of the latter association early in April. It had previously been approved by the Society's House of Delegates and the instrument is now operative for both associations.

The first section of the code contains a recommendation that persons suspected of having committed a capital offense be examined by not less than two psychiatrists, to be designated by the Commissioner of the State Department of Mental Health.

Dr. Thomas M. Feeney, Hartford, chairman of the conference committee which devised the code, has explained that the recommendation for psychiatric examination was included to indicate agreement between the two professions for such procedure in certain cases. There is no intent to seek statutory regulation at this time, he said.

"Doctors and lawyers have much in common," the introduction to the code reads. "Each is bound by a code of ethics dedicated to attaining the most worthy objectives inherent in the trust placed in each profession by the community served."

"These principles are not rules and regulations, but they are goals worthy of the aims of each profession."

The document comprises eight sections concerning medical records, improper testimony, pretrial conferences, the use of the subpoena, courtroom procedures, and contents of a physician's report for legal use.

"The medical profession," the first section reads, "recognizes its obligation to keep adequate records in order to supply to a patient's attorney all information regarding the patient-client's medical history, provided the physician has received proper authorization from the patient."

"Under no circumstances is a medical witness justified in suppressing medical evidence required by the court in its search for justice."

Stressing the importance of correct courtroom procedures, the code endorses a pretrial conference between a physician who is to testify and the patient's attorney in order that the physician may clearly understand what will be expected of him in court.

"Since no medical witness appears in the courts except those called by the attorneys or the court itself," the second principle reads, "it is of the greatest importance both to the attorney as well as the physician that no improper testimony be allowed."

Commenting that "our system of justice depends upon being able to require a citizen's attendance at a trial," the code states that "no doctor should take offense at receiving a subpoena."

"However," it continues, "attorneys should exercise their best professional judgment in having subpoenas issued to physicians. Recognizing the demands of a doctor's profession, a lawyer should make every effort to avoid unnecessary inconvenience by giving the doctor as much advance notice as possible as to the time and circumstances of his appearance in answer to the subpoena. The doctor should recognize his obligation to his patient and the courts by appearing when requested."

Meeting of the Connecticut Advisory Committee on Foods and Drugs March 28, 1957

The member societies, institutions and agencies were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut State Dental Association, Dr. William Kirschner, Jr.; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; Food and Drug Commission, Mr. Herbert Plank; Pharmacy Commission, Dr. Felix Blanc; State Department of Health, Dr. James Hart; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Yale University School of Medicine, Dr. Nicholas Giarmán.

THE SALE OF TRANQUILIZING DRUGS

Dr. Giarmán stated that Dr. Dwyer and he had not gotten together, as yet, to study the question of the dangers involved, if any, in the sale of so-called "tranquilizing" drugs, both on prescription and "over-the-counter."

He displayed a full-page advertisement which had appeared in the March 13 *Daily News*; this advertisement offered "A Tranquilizing Pill Without a Doctor's Prescription." The product was a capsule called "TR-34," said to contain "four proven seda-

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DENTOCAIN TEETHING LOTION

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Chloroform, 4 mins. per fluidounce.

Easier on the Baby . . .

DENTOCAIN TEETHING LOTION makes it easier to go through the troublesome teething period. A small amount, applied with gentle massage, brings quick, soothing relief to irritated and inflamed gum tissue, aids in getting infant back to sleep.

Easier on the Mother . . .

By providing more comfort and extra sleep for the baby, DENTOCAIN TEETHING LOTION grants the mother greater peace of mind and several additional hours of necessary rest.

DENTOCAIN has also been useful in providing temporary relief for pain of adult toothache.



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tives" and to be capable of being taken "without fear of forming a habit." The ad also contained four case histories "from the files of one of America's leading nerve specialists!" of people who were "actually rescued from despair by T-34, even after every known tranquilizer had completely failed them!" Thirty capsules were purchasable by mail from a New York corporation for \$2.98.

NEBS

Mr. Plank asked the committee's opinion on the safety and/or value of a pain-reliever tablet called "Nebs," manufactured by the Norwich Pharmacal Co., which was purchasable without prescription. The active ingredient was acetylparaaminophenol. Dr. Giarman replied that this compound was a metabolite of acetanilide; he believed it to be as potent as acetanilide, if not more so, and to have the same dangers in use.

Prof. Fenney remarked that the Norwich people must have cleared the product with the U. S. Food and Drug Administration, either through their accepting a new drug application for it or their deciding that it was not a "new" drug within the meaning of the law. Dr. Fisher agreed that this seemed likely, since the Norwich Pharmacal Co. was a large concern.

It was agreed that Dr. Giarman should investigate this subject and report at the next meeting.

THE SALE OVER-THE-COUNTER OF SODIUM SALICYLATE SOLUTIONS

Mr. Plank mentioned that he had received an inquiry from a pharmacist as to whether he could market for sale "over-the-counter" a preparation which was essentially a solution of sodium salicylate; the brand name proposed was "Taspirin." Mr. Plank asked the Committee for an opinion on the safety, etc., of such a product. Dr. Giarman and Prof. Fenney could see no objection, provided the preparation were properly labelled with dosage directions, indications for use, contraindications, etc.; sodium salicylate was official in the U.S.P. as an analgesic in adult dosage of 600 mg. every 2 to 4 hours.

Mr. Plank stated that since the product did not contain aspirin, as the proposed trade name "Taspirin" inferred, he would insist on a change in name before it was offered for sale in Connecticut.

Prof. Fenney remarked that use of a solution of sodium salicylate tends to cause gastric irritation due to liberation of free salicylic acid by the gastric

juice; also, solutions are generally to be avoided because they become discolored on standing.

Mr. Sibley to American Hospital Association

Hiram Sibley, former Connecticut Hospital Association executive director and presently director, program development, Yale-New Haven Medical Center, joined the Chicago staff of the American Hospital Association on May 1 to become secretary of its newly organized Council on Hospital Planning, Financing, and Community Relations. Mr. Sibley, who holds a Masters Degree in Public Health from Yale University School of Medicine, is a graduate of Harvard University. He became the first full time executive director of the Connecticut Hospital Association on July 1, 1948, and until April 1, 1954 led it in the period of its most active growth. Mr. Sibley is the author of numerous articles on association programming and hospital finance, and has lectured extensively on these topics at national and regional hospital conventions.

Civil Defense Planning Unified

An announcement recently received from the State Department of Health establishes its disaster emergency program as a component part of the Connecticut Civil Defense Organization, headed by the State Office of Civil Defense, 92 Farmington Avenue, Hartford 15, Connecticut. Planning for both natural and war caused disasters is unified under William H. Keeler, M.D., chief of medical and health services, State Office of Civil Defense.

Under the new plan, the Health Services Advisory Council, which includes the State Department of Health, meets monthly under the auspices of the State Office of Civil Defense for the purpose of coordination in disaster planning. Other agencies represented, in addition to the Connecticut Hospital Association, are: State Department of Agriculture, State Food and Drug Commission, Connecticut State Dental Society, Connecticut State Medical Society, Connecticut Pharmaceutical Association, Connecticut Funeral Directors Association, American Red Cross, Connecticut Regional Blood Program, State Department of Mental Health, Connecticut Osteopathic Society.

Nearly sixty hospitals, located at various points in the United States, are presently cooperating in the activity, thus permitting periodic special reports which give comparative information on the hospitals

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Machine Analysis of Hospital Records

A proposal to use data processing machines on the monthly analysis of hospital service has been accepted in four Connecticut hospitals. These are Greenwich, Bridgeport, Waterbury and Danbury. The program, conducted by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, has been the topic of joint discussions between CHA's Council on Professional Practice and the Committee on Hospitals of the Connecticut State Medical Society.

The Commission, which is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southwestern Michigan Hospital Council, uses punched cards and data processing machines to accumulate hospital service statistics. As hospital cases are discharged, summary sheets are prepared by the hospital's medical records department, and these are sent to Ann Arbor for punch card preparation. At the end of each month, an analysis of the service is prepared for the use of the medical staff records committee in each hospital.

Fairfield County

The Fairfield County Medical Association for the second consecutive year, participated in judging and awards in connection with the Eighth Annual Southern Connecticut Science Fair held at Fairfield University in April. The event was sponsored by the Metropolitan Bridgeport Science Teachers Association with the cooperation of the Bridgeport General Electric Engineers Association. Physicians participating as judges of the biology exhibits were Milton Cooper, M. David Deren, Edward Gerety, H. Patterson Harris, Jr., Alan Lerrick and Albert M. Moss. Presentation of awards to six students was made by Mr. Arnold P. Olson, executive secretary of the Fairfield County Medical Association.

June 26 is the date of the first round of play in the annual four-ball golf tournament of the Fairfield

County Medical Golf Association at Shorehaven Country Club, East Norwalk. The qualifying round was held in May at the Mill River Country Club, Stratford.

The County Medical Association has endorsed, in broad terms, the objectives of the School of Nursing of the University of Bridgeport. This action took place at a recent meeting of the Board of Trustees.

The acceptance by D. Olan Meeker, Riverside, of the post of regional member of the American Medical Association's Committee on Legislation has caused him to resign two Fairfield County Medical Association Committee offices. He has been succeeded by Warren Z. Lane, Stamford, as a member of the Public Relations Committee for a one year term and by C. Frederick Yeager, Bridgeport, as a member of the Committee on Medical Ethics and Department, a two year term. The appointments were made by President R. Harold Lockhart, Bridgeport. Dr. Lockhart has also appointed Gray Carter, vice president, William T. Clark, Bridgeport and William M. Stahl, Jr., Danbury, both members of the Board of Trustees, to a new committee to arrange programs for meetings of the County Association during the year 1957-58.

A Poison Control and Information Center, the first in Connecticut, has been established at the Stamford Hospital. Not having as yet acquired a good and up-to-date library on all matters pertaining to poisons, the Center, however, can offer the following services: (1) emergency treatment for cases brought in to the Center; (2) consultative service on a 24 hour basis in matters of poisoning; (3) a program of public education; (4) laboratory facilities for emergency toxicology. Angelo Mastrangelo, Jr. is chairman of the Center.

John H. Morrissey of Darien died of a heart attack on April 5 on the way to his office in New York City.

Hartford County

Stevens J. Martin, director of the Department of Anesthesiology at St. Francis Hospital, Hartford, was in Little Rock, Arkansas, last month where he addressed the 81st session of the Arkansas Medical Society on "Contributions of the Anesthesiologist to the Medical Profession."

Frank O. Wood, gynecologist and obstetrician at the Hartford Hospital, was the guest speaker at the 168th annual meeting of the Tolland County Medi-

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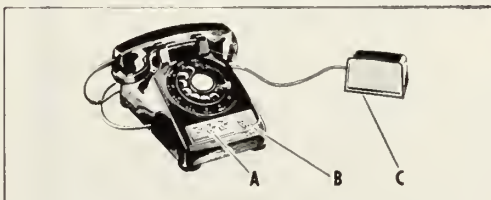


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cal Association at Somers on April 16. His subject was "Continued Experience with Carcinoma of the Cervix."

The Hartford Hospital Association sponsored a panel discussion on "Can You Be Fat and Healthy?" held in the amphitheatre of the hospital on May 14. This was a special feature in the observance of National Hospital Week and was open to the public. Stewart Seigle was moderator and the panelists were Burdette J. Buck, Theodore Steege, Wilton F. Smith and Edward Scull.

John C. Leonard attended a regional meeting of the American College of Physicians in Puerto Rico in April where he delivered three scientific papers.

Howard B. Haylett, a general practitioner in East Hartford for 40 years, died at the Hartford Hospital on May 1.

Egmont J. Orbach of New Britain addressed the third annual meeting of the American College of Angiology on June 2 in New York City on "Reappraisal of Sclerotherapy of Varicose Veins."

Richard Karpe of West Hartford is the author of "Freud's Reaction To His Father's Death" published in *The Bulletin of the Philadelphia Association for Psychoanalysis*, March, 1956.

NEW EDUCATIONAL METHOD

Hartford Hospital and St. Francis Hospital, Hartford, put in operation for the first time anywhere in the United States a teleposium on May 14. Dr. Hans Selye spoke over a closed circuit telephone line from Montreal on "Stress Theory of Hormones." Physicians gathered in the hospital amphitheatres heard the lecture and were able to participate in a direct question and answer period with Dr. Selye following the lecture. Time spent in travel was thus eliminated through this forward step in education communications.

WALT DISNEY HAS NOTHING ON UNITED AIRCRAFT

Across the editor's desk there recently zoomed a pictorial bit of literature labelled "for your information." The title on the cover, "What Everyone Should Know About Doctors," together with a Disney-like head with mirror and stethoscope supported by a fluoroscopic ill assortment of skeleton and intestines produced the desired result, the page was turned.

Pratt & Whitney Aircraft, or I suspect, its medical director, deserves an Oscar for this potent piece of visual information. Here is what it contains: a reminder of free choice of physicians; the obliga-

tions resulting from an increased life span of 20 years; what the training of a physician involves; the importance of and just what is involved in a routine physical examination; what is found in the doctor's bag; a list of standard tests and their application; a list of normal findings in ancillary laboratory tests; nineteen recognized medical specialists and the particular function of each; suggestions for choosing a family doctor; three pearls of wisdom on the back cover.

Attractive, yes; informative, very; and in this TV age, colorful, simple in its message and lacking that distracting factor, the commercial.

Litchfield County

The 193rd annual meeting of the Litchfield County Medical Association was held at the Conley Inn in Torrington on April 18. Physicians' wives were guests at the meeting. One new member was elected, Irving L. Cabot of Washington. George V. Denny, Jr. of Cornwall, former radio moderator of Town Hall of the Air, spoke on "People to People."

Royal A. Meyers of Watertown is now a licensed private airplane pilot. Dr. Meyers is one of the few Connecticut physicians who owns and operates this latest transportation facility.

Middlesex County

Ellsworth J. Smith of Clinton was surprised at the monthly physicians' luncheon in April by being presented with a book on insects. A pie, not a cake, decorated with lighted candles was also placed before him. Dr. Smith moved to Clinton from Scarsdale, New York when he retired in 1948.

Norman H. Gardner of East Hampton, regional director of the AMA Council on Rural Health, was chairman of the New England Rural Health Conference held at Pembroke, New Hampshire, on April 25.

The annual meeting of the Middlesex County Medical Association was held at the Elks Club in Westbrook. Officers elected for the coming year are: President, Vincent J. Vinci; Vice President, Harry Whiting; Clerk, Clarence Harwood. The speaker was Casto Caiazza who showed movies of some of his trips abroad. Among the guests was Stanley Osborn, State Commissioner of Health, who also addressed the meeting. Three men were elected into membership: Donald Schweitzer, who is in general practice in Deep River, and Felix Sheehan

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and Michael Villari, both of whom are in general practice in Middletown.

Joseph Manzi, who completed an internship at the Middlesex Memorial Hospital last June, returned to Middletown and took over the practice of Mario Palmieri the latter part of April.

New Haven County

One of medicine's most colorful figures, William Francis Verdi, died in New Haven on Easter Sunday at the age of 83. Dr. Verdi was a past president of the State Medical Society and clinical professor emeritus of surgery at Yale.

Arthur M. Yudkin of New Haven died suddenly in Wallingford on May 2 at the age of 65 as he was returning from the annual meeting of the Connecticut State Medical Society in East Hartford.

Charles W. Comfort, Jr., former secretary of the State Medical Society for several years, died on May 6 at the Rocky Hill Veterans Hospital at the age of 71.

Arthur Weil, a practising physician in New Haven since World War I, died early in May in Memorial Hospital, New York City, at the age of 69.

Yale University School of Medicine

John R. Paul, professor of preventive medicine, is the author of "The Soviet Program for Medical Research, 1956-1960," published in *The Yale Journal of Biology and Medicine*, February, 1957. Dr. Paul was a participant in a Medical Mission to the Soviet Union carried out under the auspices of the U. S. Department of Health, Education and Welfare during February and March of 1956.

NEW BOOKS IN REVIEW

ORTHOPEDIC SURGERY IN THE EUROPEAN THEATER OF OPERATIONS. Editor in Chief: Colonel John Boyd Coates, Jr., M.C.; editor for *Orthopedic Surgery*: Mather Cleveland, M.D., Washington, D. C.; Office of the Surgeon General. 1956. 397 pp. \$5.

Reviewed by RUSSELL V. FULDER

Embodying the collective orthopedic experience of the Army Medical Department in the European Theater, this volume is one of a series which, when completed, will survey the Department's activities in all combat theaters during World War II. Dr. Cleveland's presentation could stand as a model for the whole. The volume has been scrupulously edited, well printed and carefully indexed. It has also been generously supplied with illustrative photographs and line drawings, as well as with x-rays that come through clearly in reproduction. In addition to its significance as a soundly organized chapter of military orthopedics the work achieves

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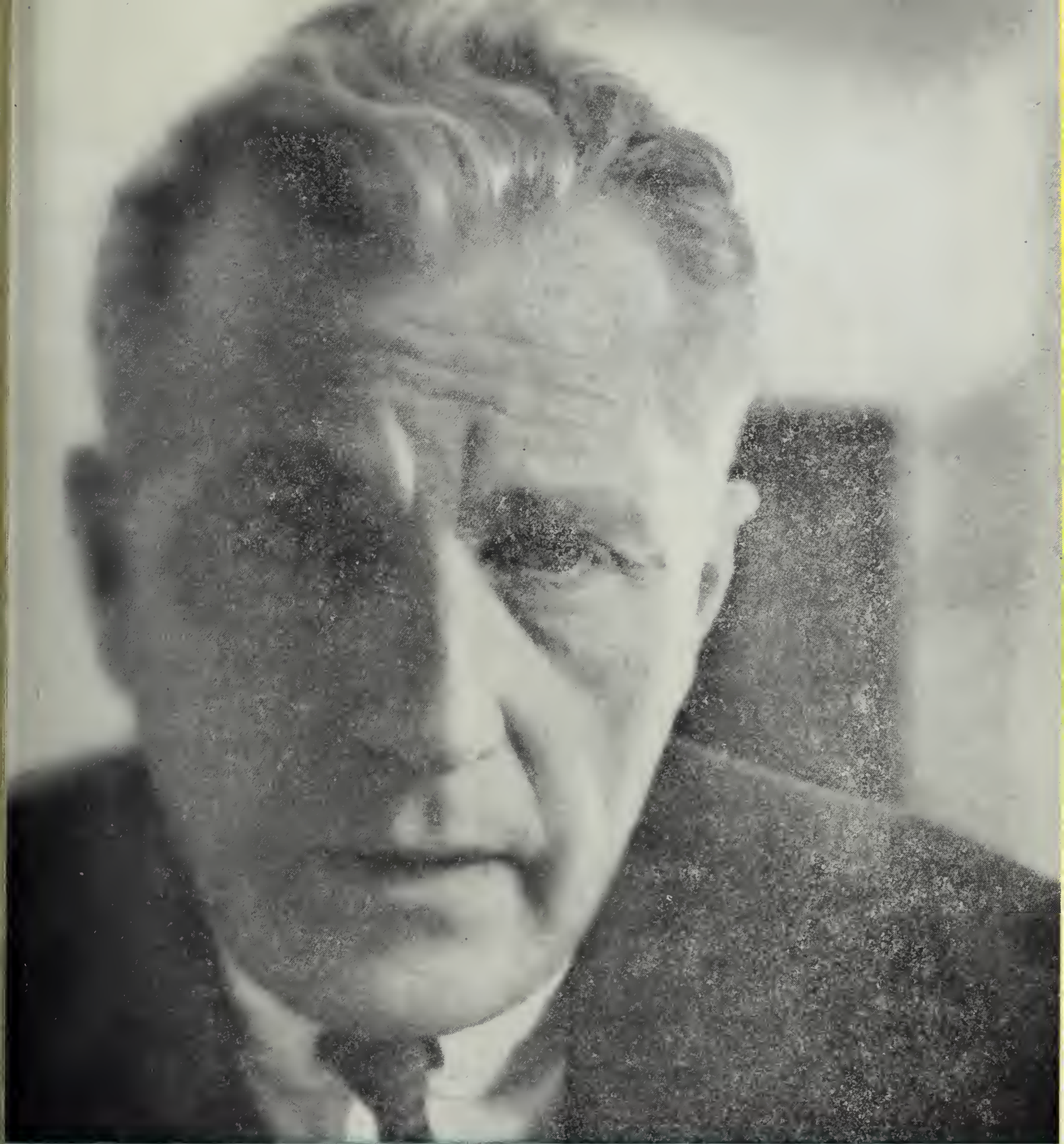
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References: 1. Borrus, J. C.: *M. Clin. North America*, In press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. Clin.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.*, In press, 1957. 4. Cayer, D.: Prolonged Anticholinergic Therapy of Duodenal Ulcer. *Am. J. Dig. Dis.* 1:301-309 (July) 1956. 5. McGlone, F. B.: Personal Communication to Lederle Laboratories. 6. Texter, E. C., Jr.: Personal Communication to Lederle Laboratories. 7. Bauer, H. G. and McGavack, T. H.: Personal Communication to Lederle Laboratories.

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distinction in presenting, and abundantly documenting, the principles underlying management of severe orthopedic traumata anywhere—lessons as applicable in New Haven as they were at St. Lô.

The editor introduces us to his subject by describing the administration of orthopedic services in a large theater of military operations. He proceeds to consideration of clinical policies in the management of orthopedic casualties, detailing directives and case reports to illustrate proper handling of regional injuries of the extremities and trunk. Brief treatment is given to such ancillary topics as rehabilitation, noncombat lesions and psychiatric complications. The second half of the work takes up, in scholarly articles written by Dr. Cleveland and by Marshall K. Uriet, dislocations of the acromioclavicular joint, hip fractures, and injuries to the knee joint.

Here are record and testimony of the giant strides taken by orthopedic surgery in World War II. Vastly improved techniques for splinting fractures and transporting casualties, the administration of blood and plasma in forward zones, prompt, thorough debridement and delayed primary closure of wounds, early skin grafting—one has only to go back to the records of the first World War to learn the meaning of such resources of skill and matériel. The advent of penicillin brought the antibiotic era into its own, and with it a totally new dimension in the treatment of wounds. Even as such gains were in the making, the enemy, a few hundred miles distant, had consolidated the next advance in fracture treatment—the principle of intramedullary fixation, as exemplified in the nail invented by Küntscher of Kiel. And

like the German experience in rocket manufacture, the design and application of the axial nail was to become one of our valued prizes of war.

FLUOROSCOPY IN DIAGNOSTIC ROENTGENOLOGY. By Otto Deutschberger, M.D., Assistant Clinical Professor of Radiology, New York Medical College, Roentgenologist in charge, Bird S. Coler Memorial Hospital, New York, Associate Visiting Roentgenologist, Metropolitan Hospital, New York. Philadelphia, Pa.: W. B. Saunders Company, 1956. 771 pages with 888 illustrations on 523 figures. \$22.

Reviewed by SIDNEY L. CRAMER

This text of some seven hundred seventy pages is a prodigious work by an author with an extensive knowledge of fluoroscopy. Though the hazards of radiation are no different today from fifteen years ago, nevertheless the present day popular scare has shifted the emphasis from the therapeutic hazard to the diagnostic, particularly the fluoroscope. This book arrives at an opportune time, it would seem. As stated in the preface, this volume should be valuable not only for the radiologist but the nonradiologist as well. This is true for the early chapters where, in a very readable style, there is presented a fund of information concerning the physics of the fluoroscopic image, the mechanical construction of the equipment, the hazards of radiation and the protection against them. When one gets into the primary subject matter, namely, the interpretation of the screen image, some doubts arise as to the value of the book to the nonradiologist. The author is careful to point out that the

x-ray film and the fluoroscope are complementary examinations but in too many areas the language of the text is such that the image of the film must be in the mind's eye in order to assign to their proper place those findings pertinent to the film only and those better seen by the fluoroscope. The nonradiologist, unless trained in film interpretation in a particular field, might find the text confusing. Also, since it is the hope of the author that his book be used as a reference text, there was no detail too unimportant to merit discussion. In so doing he fails in many instances to place relative values on the various fluoroscopic findings. He does not equate the exposure time against the ease of seeing a particular image and the value of the latter in the final analysis of the examination.

However, in anticipation of the drawbacks to the universal appeal of the book, such as described above, the author explains in detail the electron screen amplifier, already a practical reality which yields a smaller quantity of radiation thus increasing the safety of the fluoroscope, and at the same time produces a fluoroscopic image of great brightness and sharpness almost equal to the film. Through these mechanical improvements he hopes that all medical specialties would be making greater use of the fluoroscope. It would seem, therefore, that the four thousand practicing radiologists today would find this text a valued addition to their library today. For the other one hundred twenty thousand users of the magic lantern, the book's value lies more in the future.

ALBERT SCHWEITZER. *The Story of His Life*. By Jean Pierbal. New York: Philosophical Library, 1957. 160 pp. \$3.

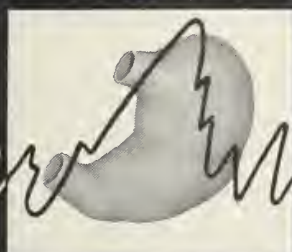
Reviewed by STANLEY B. WELD

To few are given the physical strength, the mental capacity, and the spiritual zeal to become an Albert Schweitzer. Theologian, philosopher, musician, physician—this is no ordinary man. Born in the Münster valley in Alsace, at 82 we find him still laboring in his chosen field of service in Lambaréné, French Equatorial Africa.

This is a biography in short form, so to speak. It describes his childhood experiences, his researches and travels, his suffering and dedication. It shows how a consecrated individual overcame obstacles by sheer will power and with a vision of his place in God's program for Africa offered his talents literally for the healing of the nations.

Albert Schweitzer has been accorded recognition in the United States as a great musician and student of Bach. Many simple folk of Alsace remember him as their pastor who pointed them heavenward. The natives of French Equatorial Africa acclaim him as their emancipator from the degradation of ignorance and disease. His accomplishments are little short of amazing. One feels moved to close such a book with a prayer of thanksgiving that Albert Schweitzer has been spared a long life of service to his fellowmen, black and white.

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NEW AND NONOFFICIAL REMEDIES 1957. Issued Under the Direction and Supervision of the Council on Drugs of the American Medical Association. *Philadelphia and Montreal: J. B. Lippincott Co. 1957. 582 pp.*

Reviewed by STANLEY B. WELD

This is the annual publication of the Council on Pharmacy and Chemistry (now named the Council on Drugs) of the American Medical Association. It contains descriptions of drugs evaluated on the basis of available scientific data and reports of investigations. It deals with agents proposed for medicinal or adjunctive use in or on the human body for the diagnosis, prevention or treatment of disease. Descriptions are limited to individual drugs generally available in the United States that have not been included in the Pharmacopeia of the United States, The National Formulary, or New and Nonofficial Remedies for a prior cumulative period of 20 years.

Since 1955 the scope of the volume has been expanded to provide for the inclusion of information on all available new drugs. This volume is divided into 26 chapters, each dealing with a specific group of drugs such as anesthetics, diuretics, oxytocics, etc. In addition there is a list of the members of the Council, a list of the members of Standing Committees of the Council, the Consultants during 1956, the monographs added to N.N.R. 1957, the monographs omitted from N.N.R. 1957, the purpose, principle and procedure of the Council, a statement concerning each of the official and regulatory agencies, and the tables of the metric system. A general index is appended.

This is a valuable reference volume especially as it furnishes the nonproprietary name, the chemical name, and the commercial name of each drug listed.

THOMAS PATRICK MURDOCK, M.D.

Born in Meriden, Connecticut, March 6, 1888

Died in Meriden, Connecticut, April 1, 1957

University of Maryland School of Medicine, M.D. 1910

Intern, St. Francis Hospital, Hartford, Connecticut, 1910-1911

Intern, Undercliff Sanatorium, Meriden, Connecticut, 1911

First Lieutenant, later promoted to Captain, Medical Corps, U. S. Army, 1st
World War

Chief of Medical Service, Meriden Hospital, Meriden, Connecticut, 1925-1948

Member of Board of Directors, Meriden Hospital, Meriden, Connecticut

Past President, New Haven County Medical Association

Past President, Connecticut State Medical Society

Member and in 1947 Chairman, Medical Visitors to the Institute of Living, Hart-
ford, Connecticut

Member, Board of Directors, Connecticut Medical Service

Governor, American College of Physicians, 1946-1952

Member, House of Delegates, American Medical Association, 1943-1950

Member, Board of Trustees, American Medical Association, 1950-

Past Chairman, National Committee for Improvement of Nursing Services



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Resolution on the Death of

DR. THOMAS P. MURDOCK

Passed by House of Delegates April 30, 1957

Mr. Speaker and members of the House of Delegates, I wish to present a resolution under suspension of the rules. This resolution refers to the death of Dr. Thomas P. Murdock.

In 1792 the Connecticut State Medical Society was founded by a few men of vision and that rare quality, leadership. They were pioneers in a land that had only lately become a nation. For 165 years the organization they created has grown and prospered. It has guided its members to higher standards of service to the public as in all walks of life. Each medical generation has produced many followers but only a few leaders. Our generation has been blessed with one of the great leaders—Thomas Patrick Murdock.

Dr. Murdock became a member of this house in 1923, and from that day until his death he dedicated a large part of his life to the Connecticut Medical Society and the progress of medicine in Connecticut and America. He held every high office his colleagues could bestow, president of the New Haven County Medical Association and of this Society, member and chairman of the Society's Council for many years. He was appointed by three Governors to serve four 5 year terms on the Connecticut Medical Examining Board, becoming its secretary and president. He was a director of Connecticut Medical Service, a delegate to the American Medical Association and a member of its Judicial Council. Finally, he became a trustee of the American Medical Association and was serving his second term when he died. To that important and responsible office, as elsewhere, he brought the unfailing courage, fervid spirit, and keen judgment that earned him the highest esteem from all.

We were privileged to have had him as one of us, we were closest to him and knew him best. May this House where he served so long and faithfully now record its deep respect and warm regard for him as a leader, an advocate, and a friend. His page is written indelibly in our history.

THOMAS PATRICK MURDOCK, M.D.

1888 - 1957

On the morning of April 1, 1957 after a long period of illness, Dr. Thomas Patrick Murdock died in his office in Meriden, Connecticut. Dr. Murdock was born March 6, 1888, the son of the late Patrick and Bridget Callahan Murdock, in Meriden, Connecticut. He is survived by his wife, the former Alice Keating, and two sons, Keating and Brian Murdock. He attended local schools and was graduated from Meriden High School. He then went to work to earn money to complete his education and was eventually accepted at the Baltimore Medical College, now the University of Maryland School of Medicine, from which he graduated with the degree of M.D. in 1910. He interned for one year at the St. Francis Hospital in Hartford and briefly at the Undercliff Sanatorium in Meriden.

He began practice in Meriden in 1911 and was appointed to the staff of the Meriden Hospital in 1912. He was commissioned a First Lieutenant in the Medical Corps of the United States Army shortly after our entry into World War I, but his service was interrupted by illness which incapacitated him for some time after his discharge. He returned to medical practice in Meriden and in 1925 was elected to the Medical Board of the Meriden Hospital as Chief of the Medical Service. He later became a member of the Board of Directors of the Meriden Hospital and maintained his activity and interest in the work of the hospital until he was forced to resign his active connections with it for reasons of health in January, 1948. At that time he was appointed to the Emeritus Staff.

Early in his medical career he interested himself in the affairs of the New Haven County Medical Association and the Connecticut State Medical Society. He served as President of the County Medical Association and the State Medical Society and for many years as a member and Chairman of the Council of the State Medical Society. He was also a member of the Board of Medical Visitors to the Institute For Living in Hartford and in 1947 was Chairman of that Board. He was a medical consultant to Gaylord Farm for many years and a member of their Board of Directors since 1943. During World War II he served as a representative from Connecticut on the National Committee for the Procurement and Assignment of Medical Officers to the armed services.

For many years Dr. Murdock was a member and Chairman of the Committee of the State Medical Society for Cooperation with Yale Medical School. When Yale University appointed a special committee to study medical affairs, he became a member and served until the termination of its activities. He was one of those most vitally interested in the establishment of Connecticut Medical Service and served as a member of the first Board of Directors. In 1956 he was appointed a Commissioner at Large for the organization of National Blue Shield Medical Care Plans.

Dr. Murdock was a founding member of the American Board of Medicine and a member of the American College of Physicians, which he served as a Governor from 1946 through 1952. He served as a member and Chairman of the National Committee for the Improvement of Nursing Services under the National Committee for Improvement of Care of the Patient. He served as a member of the American Medical Association's House of Delegates from 1943 until 1950, when he was elected to the Board of Trustees. He was re-elected to the Board in 1955.

Dr. Murdock was a charter member of the Meriden Rotary Club but had resigned some years before his death. He was a Fourth Degree member of the Knights of Columbus

and also a member of the Ancient Order of Hibernians, the Eagles, and a life member of the Brotherhood of the Benevolent Protective Order of Elks.

Dr. Murdock was justifiably proud of his rise from humble beginnings to a position of the highest eminence and greatest respect in the medical profession. After his re-election as a Trustee of the American Medical Association, he would have been a strong candidate for the presidency had his health permitted. It was a source of regret to him that his illness prevented him from taking a more active role as a Trustee during the past three years.

In every medical and social contact he could be found aligning himself on the side of the underdog, even if this made him a minority of one. This sympathy he extended to all of the unfortunates with whom his practice brought him into contact as those who needed more understanding and help which he conscientiously gave them. Although as a physician he was well loved by many patients, he had particularly the reputation of enjoying the best relations with those whom others found to be the most difficult.

Increasingly as the affairs of organized medicine occupied the time which he could spare from his practice, tending to these matters became his recreation and his pleasure. In his younger days he had been an enthusiastic follower of sport, particularly boxing, baseball and horse racing. He rarely missed a championship fight or a world series, and continued his interest in these sports throughout his life.

He remained a constant and diligent reader, consistently finishing the many medical journals which were sent to him the evening that they arrived. His taste was chiefly for biography, the more adventurous the life the better. When in New York he regularly attended the theater for which he had the greatest love. He often said that he never saw a show that he didn't like. He had a keen sense of humor and a remarkable memory for amusing anecdotes from his own personal experience.

Although a life-long adherent to strict temperance, he enjoyed company and the often convivial sessions of his colleagues where he would come as early and stay as late as anyone. At staff meeting or delegate meetings he listened keenly, seldom speaking until the crucial point of discussion, and only then to summarize a position, suggest a compromise, though never on principle, or to bring out a fresh or neglected point of view. As chairman of a meeting, he was direct, efficient and unfailingly courteous.

In his home town of Meriden he will best be remembered for the time and interest he gave to the development of the Meriden Hospital. In addition to his devotion to the constant extension and improvement of its medical services, by his personal influence he interested the leading business and industrial people of the town in active participation as directors. He thus helped bring about organizational and physical improvements which matched those in the field of medicine. He was always on the side of young men and encouraged them to take positions of responsibility and leadership in medical affairs as quickly and as extensively as their capabilities warranted it.

If his philosophy could be summed up in two attitudes, they would be his unquenchable and inexhaustible interest in belief in medical progress and an extremely strict conception of personal devotion to duty. He backed these up with exceptional moral fortitude and a physical courage which, in his last illness, led him to accept surgery of heroic magnitude, which had rarely, if ever, been performed on a man of his age. He knew well the meanings of pain and of fear but he never waived in his intention. He died as he would have wished it, in the performance of his duty at his desk in his office.

Allan J. Ryan, M.D.

A Memorial From the Connecticut Medical Examining Board

When Thomas Patrick Murdock died on April 1, 1957 the profession of medicine in America, and particularly in Connecticut, lost one of its great leaders who was always ready to serve the public and his medical colleagues. Organized medicine bestowed upon him almost every office requiring intelligence and integrity. He served as president of the Meriden Medical Association, the New Haven County Medical Association, president of the Connecticut State Medical Society and chairman of its Council, and for nearly ten years was a trustee of the American Medical Association.

Dr. Murdock became a member of this Board in 1928, and immediately after his appointment became its secretary, an office that he held until 1941. He served a total of twenty years as a member of the Board, asking that he not be reappointed at the termination of his fourth appointment December 31, 1948. From 1947 until retirement he was president of the Board. During all of this time he was prominent in the affairs of the Federation of Medical Examining Boards of the United States, and directed great skill and understanding to the improvement of medical licensing procedure in Connecticut.

It is rare, indeed, that a physician has done so much for his profession that he did not have to do, and this memorial to his wisdom and diligence is inscribed in the records of the Connecticut Medical Examining Board with respect and affection.

John D. Booth, M.D., President

House Joint Resolution Adopted by the Connecticut General Assembly April 4, 1957

Resolved by this Assembly:

Whereas, Dr. Thomas P. Murdock, a fine and beloved physician of the town of Meriden has passed away; and

Whereas, in his passing, his own and the State of Connecticut have lost a trusted and good person who served his fellow men throughout his forty-seven years of practicing medicine and especially during his years as chief of medical service and chief of staff at the Meriden Hospital; and

Whereas, Dr. Murdock aided mankind in his many civic activities and as president of the Connecticut State Medical Society and the New Haven County Medical Association, as a governor of the American College of Physicians, as a member of the board of trustees of the American Medical Association and as a commissioner-at-large of the Blue Shield Medical Care Plan; and

Whereas, the town of Meriden, the State of Connecticut and the United States of America have lost a veteran of World War I who was prominent in many organizations and who never ceased to work for the salvation of the human resources of the nation;

Be It Resolved, that the members of the General Assembly extend their sympathy to the widow of Dr. Thomas P. Murdock, a man who held an unparalleled position of respect.

Be It Further Resolved, that the Clerks of the House and Senate cause a copy of this resolution to be sent to Mrs. Thomas P. Murdock, his daughter and his son.

TRIBUTES TO DR. MURDOCK

Thomas P. Murdock, member of the Board of Trustees of the American Medical Association, died at his home in Meriden, Connecticut, on April 1, 1957. In his death the medical profession lost one of its finest characters and the members of the Board of Trustees lost a valued counselor, a worthy colleague, and a loyal friend. It is fitting that the Board should pause in its deliberations to pay tribute to his memory.

Tom Murdock was a gifted physician. His sound training in the fundamentals of medicine, his capacity and zeal for study, his keen mind and his diagnostic acumen made of him an internist whose advice and counsel was sought by patients and colleagues alike.

Tom Murdock was a leader of men. He belonged to many organizations—medical and nonmedical, local, state and national—and in almost every instance he eventually became the president or chairman or member of the board of trustees. Those who worked with him recognized his worth and elevated him to these positions of prominence.

Tom Murdock was a servant of his fellowman. No task was too great, no work too menial if he was convinced that in the performance of that task he would render a service. And when the work was done he did not seek the plaudits of the crowd but was satisfied with the knowledge that he had done his duty.

Tom Murdock was a deeply religious man. His faith was no superficial coating for the world to see; it was a deep and abiding force which activated his very life. He loved his church, and he loved his God.

Tom Murdock was a true and trusted friend. His winsome smile, his keen sense of humor, his forthrightness, his courage, his sincerity, his honesty, and his genial personality endeared him to those who knew him. To know him was to love him for he had a gift for friendship which is given to but few.

Tom Murdock has gone to his reward, but his memory will ever be treasured by those of us who knew him so well—the memory of a great physician, a beloved friend, and a Christian gentleman.

Board of Trustees

American Medical Association

April 1, 1957 will long be remembered as a sad day in history for innumerable physicians and countless American citizens, for on that day Dr. Thomas Patrick Murdock went to his heavenly reward.

No finer gentleman ever lived. No better physician ever practiced medicine. And no truer friend could anyone ever boast of than Tom Murdock.

My close association with Tom on the Board of Trustees of the American Medical Association for the past six years convinced me beyond any shadow of a doubt of his honesty, integrity and high ideals.

Never would Tom depart one iota from right as he saw it, and he would defend unto death the principles for which he stood.

Not only have the people of Meriden lost a loyal and faithful servant, but we of American medicine have lost an outstanding leader. Seldom is it one's privilege to meet a gentleman with as many fine qualities as Tom had and his passing to his reward is a great loss to all of us who remain here.

David B. Allman, M.D., President, American Medical Association

It was my privilege to be associated with Tom Murdock for over 10 years and I am very proud of this association. Tom was a man with firm and deep moral principles combined with a broad tolerance for those who disagreed with him. I have known him to champion a cause that he thought just, even though he stood alone. After he had studied a subject he was able to present an impersonal opinion, as he was fortunate in having a very analytical mind. Tom Murdock's services to organized medicine will be missed as the years go on. He gave a great deal of time and effort to further the cause of his colleagues. Our profession needs more men like Tom Murdock.

George F. Lull, M.D.,

Secretary and General Manager, American Medical Association

Tom Murdock was a remarkable man, an outstanding man. He had a capacity for friendship and a gift for leadership which drew men to him. I know of no one in the profession who had more loyal friends or fewer critics than did he.

Tom had certain qualities which stood out. He had a keen sense of humor which, coupled with his winsome smile, gave a sparkle to his conversation and zest to his social contacts. He was a man of integrity and the big question which had to be answered for him when a proposition was under consideration was, "Is it right?" Once his decision had been made he was ready to stand up for his convictions against any odds. Tom was a team worker and when assigned a task, however great or menial, he accepted his assignment and did his best.

The greatest factor in Tom's life, however, was his deep religious faith. It was not a cloak which he donned for special occasions but a spirit which permeated his thoughts and actions. He loved his Church and he loved his God. During the latter months of his life he knew that he was living on borrowed time and yet, as he expressed it to me one evening, "I don't know just what lies ahead but I am ready."

Perhaps a little incident will tell more of Tom than a great many words. We were having breakfast together at the Palmer House. Sitting at a nearby table were two Catholic Sisters. "Bring me their checks," Tom said to the waitress, "and just tell the Sisters that a friend has paid the bill."

Soon after I returned from the last meeting of the Board which Tom attended I received a note from him expressing regret that the hours had been so taken up with business that there had been no time for just sitting and talking. Little did I realize when I answered his letter, inviting him to come South for a visit, that the end was so near. Tom Murdock has gone, but his memory will ever be cherished by those who knew him, the memory of a great physician, a loyal friend, and a Christian gentleman.

Julian P. Price, M.D., Member, AMA Board of Trustees

It was my privilege to have had Tom Murdock as a friend and I mourn his passing, as do the rest of his host of friends. He was a great man and a great soul. The sweetness of his character lingers in the memory of everyone who had a chance to know him. Eyes still light up when his name is mentioned.

The highest type of physician, who never lost touch with a busy practice of medicine, he worked above and beyond the demands of his own patients to make valuable contributions to the welfare of science, medicine and mankind. His many achievements in life reflected the character of a man with an unquenchable love for humanity.

Among his other activities Tom Murdock was devoted to the fight against poliomyelitis. He often said that the National Foundation for Infantile Paralysis was close to his heart. He demonstrated his devotion to the cause and the organization by many years of faithful service on five of the National Foundation's top-level medical advisory committees.

He first accepted appointment in 1948 to the Committee on Education and Publications and served thereafter on the General Advisory Committee, the Research Fellowship Committee, the Committee for Research on the Prevention and Treatment of After-Effects (of Poliomyelitis), and the Vaccine Advisory Committee.

He was one of the original members of the Vaccine Advisory Committee and in effect the representative of organized medicine. He acted on this committee during the crucial and trying days when it had to decide whether or not there would be a vaccine field trial. He brought to all deliberations the courage, insight and tempered wisdom needed for making critical decisions.

In October, 1954 the state of his health finally made it necessary for him to submit a most reluctant resignation from all four committees on which he was serving. "In doing it," he wrote, "my heart is heavy and sad . . . I promised I would cling to the Foundation as long as I could. The time has arrived when I feel I must give up."

I remember Tom Murdock with affection for his warm, sympathetic personality and with respect for his sound, scientific judgment. His reassuring counsel and advice were of immense value to me and the National Foundation on innumerable occasions.

Gracious and mild mannered, yet resolute and straightforward, he had a genius for taking the heat out of controversy and using it to warm the cockles of the heart. He was the kind of man to whom one would turn in time of deep trouble. A medical colleague said of him: "I have seen Tom Murdock and I feel as if my soul has been washed again."

The greatness in this man was not excellence in one particular thing but a combination of those characteristics, not alone of the intellect, that make for goodness and fineness.

Basil O'Connor,
President, The National Foundation for Infantile Paralysis

Recently, when Tom Murdock left us to join his Heavenly Father, he left behind him a heritage rich in service to his fellow man, both nationally and internationally. These services will long endure.

Medicine was the medium through which Tom emulated the Physician of Nazareth, bringing comfort, courage and a sense of well being to all with whom he came in contact.

To us, who were privileged to work with him in the State and National medical organizations, his keen sense of justice and fair play was paramount. Always the recipient of medical care was his first consideration.

During discussions of various types he had a habit of crossing his legs and moving his foot up and down. As this activity speeded up we always knew he had weighed the problem pro and con and that a sound solution was forthcoming.

I will always be thankful for his little acts of friendship. Somehow he could sense when I was in doubt about something and a little note with a few lines of encouragement or praise would suddenly appear in my mail. No doubt hundreds of other physicians throughout the country have received similar notes, signed "Tom."

Oliver L. Stringfield, M.D.,
Past President, Connecticut State Medical Society

Dr. Thomas P. Murdock, at the time of his death, was an active, respected and effective member of the Board of Directors of Connecticut Medical Service. His association with this project goes back to the period of early exploration and research by the medical profession of Connecticut in their endeavor to evolve a practical solution to the rising problem of coupling up with the sound principles of American medical practice an acceptable scheme for prepayment coverage of the costs. While his name does not appear on the roster of committees that did the spade work for the planning that led to the development of our CMS, all of those engaged directly knew of his interest and valued his wise concepts of the basic social problems involved. With keen insight, borne of his wide community practice, he understood the desire of people generally to be independent, either of charity or of governmental subsidy, and yet financially able to enjoy the best medical service as needed. His influence was always clearly expressed for progress with a very practical slant. He had long been accorded the portion of elder statesman in the councils of medicine.

He was elected to the Board of CMS in 1953, bringing to our deliberations the benefit of his wide experience in the fields of medical economics, and in particular his intimate knowledge of the socio-political aspects of medicine as currently developing. All who were privileged to work by his side loved the man for himself, his so evident sincere faith in people, his kind considerate attitude and his habit of getting to the essential elements of any matter.

His Connecticut confreres were honored by his appointment from the American Medical Association to the Blue Shield Commission. He was able to serve here for all too short a time, but did make a contribution of solid influence in the National picture for stability of purpose in extending the service features of the Plans. From his vantage point in the national councils of medicine, he was enthusiastic in his reports of the important position acquired by our Connecticut plan as a leader in the national picture.

We of Connecticut Medical Service acknowledge the loss of a wise advocate of the basic objectives of our Corporation. Dr. Tom, in deliberations, was a philosopher who could hold to the long term view and not be diverted by the trivial annoyances of the moment. His serene adjustment to the vicissitudes of life and his dedication to Service will always be an inspiration to those who have worked with him and shared his rare gift for friendship.

Robert S. Judd, Chairman of Board, Connecticut Medical Service

Yale University lost a good friend when Dr. Thomas P. Murdock died at his office desk on April 1, 1957.

Born in Meriden, March 16, 1888, he graduated from the Meriden High School, obtained his M.D. from the University of Maryland in 1910, interned at St. Francis Hospital, Hartford, and Undercliff and practiced medicine in Connecticut throughout his career. For many years he was chief of the Medical Service and Chief of Staff at the Meriden Hospital.

An able clinician devoted to his patients, he also took responsible part in the direction and policy making of many professional organizations. His primary objective was always to improve the care of the patient. He served at various times as president of the New Haven County Medical Association, Connecticut State Medical Society, as a member of the Board of Trustees of the American Medical Association, as a commissioner of the Blue Shield Medical Care Plan and on various national studies, among these the National Committee for the Improvement of Nursing Service, and the National Commission for the Improvement of the Care of the Patient. He was on the Board of Medical Visitors at the Institute of Living in Hartford and the Board of Directors of the Gaylord Farm Sanatorium in Wall-

ingford. He served in the Medical Corps in the first World War and was a member of the Procurement and Assignment Commission for Physicians in World War II.

He was an active parishioner of St. Joseph's Church and a member of various fraternal orders. He had a rich family life.

Though not a Son of Yale, or professionally affiliated with the teaching staff of its School of Medicine, or the Grace-New Haven Community Hospital, he nevertheless contributed importantly to their programs.

With sympathetic understanding of the problems of medical education, he served ably throughout the years in his various roles in professional societies, local, state and national, as a valued critic, consultant and interpreter. Not the least of these services were those contributed to the Committee on Medical Affairs of the Yale University Council from 1947 until 1955. During this period Dr. Murdock's advice and counsel helped with many knotty problems involving complicated interrelationships between the professional Schools of Medicine and Nursing, the hospital, practising physicians and the community at large.

Dr. Murdock had a keen, analytical mind. He was kind. He was a medical statesman and a realist. He gave freely and frankly from his rich experience without reserve.

In common with countless others, the Yale School of Medicine acknowledges with gratitude its own indebtedness to Dr. Thomas P. Murdock and orders that an appropriate copy of this minute be transmitted to Mrs. Murdock with deepest sympathy and appreciation.

Board of Permanent Officers, Yale University School of Medicine

It is with a sense of personal loss in the death of Dr. Tom Murdock that I express the feeling of all of the members of the Board of Directors at the Institute. No need for me to emphasize Dr. Murdock's friendship for this organization.

In the name of everyone here, therefore, I would like to express to the Medical Society our deep regret at the passing of this fine clinician and gentleman. A record of his excellent work will be made in the permanent minutes of this organization.

Staunton Williams, President, The Institute of Living, Hartford, Connecticut

Dr. Thomas P. Murdock died as those who knew him well think that he would have preferred to die—at his office desk. It was typical of the man that he kept going up to the last moment in spite of his long bout with ill health. Even after he retired from active practice and had withdrawn from direct participation in the affairs of the Meriden Hospital, he continued to serve the interests of his profession—and the public—in countless ways. He lived his life up to the hilt, never sparing himself when there was good to be accomplished.

Meriden has been blessed with many distinguished men of medicine whose careers live on in the history of the community. But we venture to state that none has left a deeper mark than Dr. Murdock. He was both wise and well beloved. His story was that of the boy who made good in his home town and rose to honors such as few men achieve. He won distinction not only in the State but throughout the nation. Many Meriden residents, mentioning his name while traveling have *learned* that he was known from coast to coast in person and by reputation. His achievements for the improvement of nursing service and

patient care were widely recognized. He was a physician's physician, a doctor to whom other doctors turned when in doubt, and he usually knew the answers.

The Meriden Hospital acknowledges a great debt to Dr. Murdock. For years his was one of the principal professional voices in its administration, and he has continued to furnish counsel, when sought, ever since his name was placed on the emeritus list.

* * * * *

Dr. Murdock will be best remembered for his qualities as a man to whom any might turn in time of distress, sure of a kindly ear and help where it counted most. His love of humanity was unfailing. His philosophy was built upon the firm belief that there is a brotherhood of man. His religious faith was deep and profound, and he took constant inspiration from it in his daily life.

Dr. Murdock's passing has taken from Meriden one of its foremost citizens. In paying tribute to his achievements, we have only echoed what is being said on all sides. He will be greatly missed.

Editor, *The Meriden Journal*

Resolution on Murdock Scholarship Fund Passed by House of Delegates April 30, 1957

On the passing of a distinguished leader it is a widespread custom for organizations to adopt a resolution expressing their sorrow and loss. Such a resolution was presented earlier in this meeting. The contribution of some men has been so significant that a special memorial has been established to perpetuate their memory. Such a man was Thomas Patrick Murdock. It would be no more than fitting that a Memorial be established in his name. But he was no ordinary man and no ordinary memorial would be suitable. Therefore, Mr. Speaker, I would like to make the following proposal:

That the Connecticut State Medical Society establish and sponsor a fund to be known as the Thomas Patrick Murdock Scholarship Fund. Contributions to such a fund shall be accepted, not only from the ranks of medicine but from the many lay organizations and individuals who have been privileged to be associated with Dr. Murdock in his various fields of activity.

The purpose of this fund is to provide scholarships or loans to further the medical education of one or more Connecticut students whose intellectual and academic attainments are high, but in particular who give promise of superior leadership.

I further propose that the establishment and administration of this fund and the authority to select a candidate or candidates, be placed in the hands of the Council, by authority of this House of Delegates, with the power to proceed along appropriate lines; and that the Council report its progress to this House at the next semi-annual meeting.

Mr. Speaker, I move the approval of this proposal.

REPORT OF CASE OF GRANULOMA INGUINALE

THOMAS P. MURDOCK, M.D., *Meriden*

DUE to the rarity of this condition in this locality, and due to the fact that this patient is a native of Connecticut, and has not been to the tropics, or in the south, I think it advisable to report this case.

Dr. John Lane¹ saw a typical case of granuloma inguinale at the New Haven hospital about one year ago. As far as I have been able to determine, these are the only two cases reported in Connecticut.

Much has been written about this condition in the past few years. Probably the first case recorded was by Macleod in India in 1882. This was quoted by Walker² in 1918.

Practically all of the cases reported, with the exception of those cases reported by Campbell³ in New York State, have been reported in the southern part of the United States, or in the tropics.

ETIOLOGY

Many causative agents have been ascribed to this condition. However, since Donovan's⁴ description of the causative factor in 1905, practically all observers are agreed on the importance which this micro-organism plays in the production of this disease.

The organism as described by Donovan is an encapsulated gram negative coccoid, and diplococcibacillus. It has been reported that pure cultures of the organism have been obtained. In the case reported here, the author was unable to obtain a pure culture.

Gage⁵ believes that, in the majority of cases at least, it is a primary infection of the genitals, transmitted through sexual intercourse; however, he believes that the condition may be complicated by syphilis, or chancroid.

Campbell,⁶ on the other hand, lays great stress on the importance of previous infection, such as bubo, or trauma, such as circumcision.

Lynch⁷ believes that frequently the condition is associated with syphilis, or the patient gives a history of syphilis in which a serologic cure has been established.

The case here reported is apparently of the so-called pure type due to the absence of associated conditions or traumatism.

DIAGNOSIS

The diagnosis of this condition is established by finding Donovan bodies in the smear. Two methods are advocated for obtaining smears: One the removal of a small section, and squeezing the tissue fluid, making smears from this fluid. The other, thoroughly cleansing the ulcerations with ether; after the bleeding has been controlled, removing, with a dull curette, some of the scrapings, from which a smear is made. The latter was the method used in the case here reported. Romanowsky's stain was used with excellent results.

The differential diagnosis of this condition presents considerable difficulty. The conditions with which granuloma inguinale are likely to be confused are syphilis, tuberculous ulcer, cancer, and chancroid.

A blood Wassermann should be done on all these cases, although, as Lynch⁸ has pointed out, it is not uncommon for syphilis to be associated with this condition.

Patients with chronic indurated ulcerations in this region should be given the benefit of repeated smear examinations. The finding of Donovan bodies in the smear establishes the diagnosis.

TREATMENT

In the case here reported, no local application of any kind was made. This was purposely done to be able accurately to determine the value of tartar emetic intravenously.

The method used was that outlined by Campbell,⁹ and later by Gage.¹⁰ One Gm. of finely powdered tartar emetic was added to 100 cc. of freshly distilled water. The solution was then thoroughly boiled. Intravenous injections were used every other day, beginning with 2 cc. of tartar emetic solution diluted with 8 cc. of freshly distilled water. With

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each succeeding administration, 1 cc. of tartar emetic was added, and 1 cc. of distilled water subtracted. All told, eighteen injections were given.

Following the third injection, there was a noticeable decrease in the secretion, followed by rapid epidermization. The lesions were entirely healed following the last injection. The patient has been advised to take monthly injections of tartar emetic for one year.

Great care should be used in the administration of tartar emetic intravenously. Frequent examinations of the urine during treatment is advised.

The appearance of albumin and casts in the urine during treatment should be a warning sign to temporarily discontinue treatment.

Infiltration of the drug in the tissues around the vein is extremely painful, and likely to cause sloughing.

A cure has apparently been established in this case.

REPORT OF CASE

F. M. Age 28 years. Mechanic. The patient had influenza in 1919, otherwise the past history was negative, or unimportant.

I saw the patient in consultation on March 26, 1924. He was exposed (by sexual intercourse) to infection one month before onset of present trouble. The history obtained was that the lesion manifested itself three weeks before as an elevated papule, with subsequent ulceration on the shaft of the penis. Six days before examination, another papule, with subsequent ulceration, appeared in the right groin.

The general physical examination was negative. The blood Wassermann was negative.

The lesions occurred on the shaft of the penis and in the right groin. The former was serpiginous in type, its longest measurement being $4\frac{1}{2}$ cm., its widest 2 cm. The latter was annular, and its diameter 2 cm.

The lesions were elevated, and hard to the touch. The ulcerations were not deep, but were typically granulo-

matous. The edges presented an elevated, rolled out appearance. There was a slight seropurulent discharge coming from both lesions. There was a marked odor from the lesions. The penis also presented the appearance of a mild elephantiasis. The lymphatic glands in the groin were not enlarged. Smears obtained from the scrapings of the lesions showed Donovan bodies.

The patient was given tartar emetic intravenously. In all, to date, he has received eighteen intravenous injections of tartar emetic.

CONCLUSIONS

1. A case of granuloma inguinale is here reported occurring in the northern part of the United States.
2. The organism described by Donovan in 1905 in all probability is the causative factor of the disease.
3. Tartar emetic appears to be specific, particularly in the so-called pure or uncomplicated cases.

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RICH LIVER DIET IN THE TREATMENT OF ANEMIAS WITH REPORTS OF CASES

THOMAS P. MURDOCK, M.D., *Meriden*

THIS paper is a report of six cases of pernicious anemia, four cases of secondary anemia, one case of atypical secondary anemia, and one case of Hodgkin's disease treated by a diet rich in liver, after the method of Minot and Murphy.¹

Whipple and Robbins² have said: "Any person who works with standard anemia dogs, and observes the ease with which hemoglobin regeneration can be controlled by diet factors, comes to believe that many types of human anemia may be treated to advantage by diet control, rather than by other methods."

Prior to the Minot and Murphy paper of last year, very little consideration had been given to diet in the management of the anemias. Transfusions and iron and arsenic were used in the treatment of these cases. Following the Minot and Murphy report, however, much impetus was given to the dietary management of primary and secondary anemias.

The following cases were observed, either on the medical service at the Meriden Hospital, or in private practice. In all cases dilute hydrochloric acid was used, the usual dosage being a teaspoonful three times daily. In no cases was iron or arsenic given.

The diet as outlined by Minot and Murphy was strictly adhered to in all cases of primary anemia, and in the severe cases of secondary anemia. The diet outlined in ounces for the benefit of patients is as follows:

Calf or beef liver, sweetbreads, or kidney.....	4 to 8 ounces
Lamb or beef.....	4 to 8 ounces
Vegetables (particularly spinach and lettuce).....	16 ounces
Fresh fruit.....	8 to 16 ounces
Milk	8 ounces
One egg.	
One ounce of fat made up of butter and cream.	

In the moderately severe cases of secondary anemia, a diet which was arbitrarily called a modified Minot diet was used. With this latter diet the patient was advised to restrict fats and to take

generously of liver or kidney, or sweetbreads, lamb, or beef, green vegetables, and fruits. The response to the diet was very much more rapid in the cases of secondary anemia than in the primary anemia.

Recently McCollum,³ Simmonds and Becker have reported their work with vitamin E. They conclude that liver fats contain large amounts of vitamin E and iron, and believe that the value of the liver diet recommended by Minot and Murphy lies in its content of vitamin E and of iron.

It is fair to presume that the real value of the treatment is in the use of liver itself, and that probably the future will bring forth something in the way of liver fats or emulsions to manage these cases. This is of value because it is not uncommon to receive complaints from patients who tire of the strict dietary regimen. If in the future these people are permitted to take a regular diet, and in addition liver fats, the problem will be made much easier, both for patient and physician.

The economic problem, always a great one in the care of people with pernicious anemia, has very largely been solved by the new dietary regimen. In the past with the prognosis eventually bad, it seemed hard to have to send these people repeatedly to the hospital for transfusion. The hospital had to be paid, likewise the donor, occasionally the physician, and all of this with a known hopeless prognosis. The dietary regimen would seem to be within the reach of all.

That the liver diet has a specific action seem to have been proven by the recent work of Murphy⁴ and his co-workers. They have shown definite changes in the blood composition in cases of pernicious anemia, treated with a rich liver diet. In this work they report a definite increase in reticulocytes which occurs usually between the fourth and tenth days. This is associated with a decrease in the bile pigment concentration. Coincidentally there is an

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increase in the red cell count, and hemoglobin concentration, and a return to a color index of one or less than one. The liver diet did not produce any change in the non-protein nitrogen of the plasma, although the protein of the corpuscles increased markedly.

REPORTS OF CASES

PRIMARY ANEMIA

Mrs. E. P. Age: 37 years.

Admitted to hospital October 5, 1926. History of increasing pallor, and weakness of two months duration. Sickly, yellowish pallor of skin. Tongue smooth. Slight oedema of lower extremities. Gastric contents showed no free HCL. Gastro-intestinal x-ray series negative. R.B.C. on admission, 1,570,000, Hb. 30 per cent, W.B.C. 7,600. Smear typical of primary anemia. Blood Wassermann negative. Spinal fluid Wassermann negative. Cell count 6, blood nitrogen 36 mgs. Blood sugar 105 mgs. Clinical diagnosis: Primary anemia.

Treatment: Minot diet.

Dilute hydrochloric acid, 1 dr. T. I. D.

Patient showed almost immediate clinical improvement; headaches disappeared, she felt much stronger, lost all gastric symptoms, color became better. Discharged after thirty days in hospital with R.B.C. 3,550,000, Hb. 60 per cent. Count two weeks after discharge, 4,580,000 with Hb. 90 per cent. Patient looks and feels entirely well. Reported on March 1 as being entirely well. Hb. 90 per cent. Had not been entirely adhering to regimen.

BLOOD PICTURE

DATE	R.B.C.	Hb.	W.B.C.
10/5/26	1,570,000	30%	7,600
10/7/26	1,880,000	30%	7,600
10/11/26	1,840,000	34%	12,400
10/14/26	1,940,000	35%	7,000
10/20/26	2,200,000	45%	4,800
10/18/26	2,660,000	45%	6,200
10/23/26	2,290,000	55%	5,500
10/26/26	2,120,000	65%	6,400
10/28/26	2,870,000	65%	5,800
10/31/26	3,480,000	55%	7,200
11/2/26	3,777,000	55%	5,800
11/4/26	3,590,000	60%	5,300
11/6/26	3,550,000	60%	7,800
11/20/26	4,580,000	86%	7,400

Mr. W. B. Age: 34 years.

Patient was first seen in December 1, 1922 with the usual signs of pernicious anemia: indigestion, weakness, exhaustion, and sore tongue. R.B.C. 2,352,000. W.B.C. 3,600. Hb. 50 per cent. Patient was transfused twice at that time.

In this case it was noticed that the patient apparently commenced to relapse and he was placed on rigid Minot diet. His response was almost immediate, with a marked increase in red cells, and hemoglobin. The last count showed a very definite improvement, not only subjectively, but in general appearance of the man and the blood picture.

DATE	R.B.C.	W.B.C.	HGB.
February 9, 1923	5,928,000		100%
April, 1923	5,084,000	5,400	60%
June 6, 1923	4,800,000	6,200	70%

Was seen again on June 5, 1926 with a history that he has been feeling tired for the past month, and indigestion and weak feeling.

DATE	R.B.C.	W.B.C.	HGB.
June 5, 1926	4,224,000	4,000	70%
June 8, 1926.	Was given 475 cc. of citrate of blood.		
June 13, 1926.	Was given 500 cc. of citrate of blood.		

DATE	R.B.C.	W.B.C.	HGB.
June 22, 1926	4,780,000	7,600	80%
July 13, 1926	4,016,000	7,400	70%
November 22, 1926	3,200,000	7,000	70%

At this point patient complained of exhaustion, sore tongue, and headache, and was placed on rigid Minot diet.

DATE	R.B.C.	W.B.C.	HGB.
December 20, 1926	4,608,000	4,800	80%
February 14, 1927	5,120,000	8,600	92%

PRIMARY ANEMIA WITH CENTRAL NERVOUS SYMPTOMS

Mrs. J. G. Age: 45 years.

Patient admitted December 29, 1926, complaining of generalized weakness, numbness and weakness in lower extremities; vague complaints referable to stomach. On examination patient was an undernourished, pale, prematurely gray woman. Large patches of brownish pigmentation over skin. Tongue red and smooth.

Gastric analysis showed achlorhydria. Spinal fluid negative. R.B.C. 3,390,000, W.B.C. 5,200, Hb. 70 per cent. Put on Minot's diet, hydrochloric acid, dr. 1, T.I.D. before meals.

BLOOD PICTURE

DATE	R.B.C.	HGB.	W.B.C.
12/29/26	3,390,000	70%	5,200
12/30/26	3,420,000	60%	5,800
1/3/27	3,080,000	51%	5,400
1/8/27	3,940,000	69%	5,200
1/10/27	3,600,000	70%	6,000
1/13/27	4,120,000	75%	6,600
1/15/27	4,000,000	85%	5,800
1/19/27	4,030,000	90%	6,200
1/22/27	4,380,000	90%	7,400
1/25/27	4,670,000	85%	7,800
1/29/27	4,040,000	80%	7,800

Patient did very well, became stronger, gastric symptoms disappeared, color improved. No improvement, however, in power of legs nor in numbness. Paresthesia in legs still present on discharge. Stay in hospital was thirty-seven days.

PRIMARY ANEMIA

Miss A. S. Age: 42 years.

Entered hospital, February 7, 1927. Patient gives history of anemia of some years duration. Has been quite weak of late; breathlessness on exertion, dizziness.

On examination, patient showed typical findings of primary anemia. R.B.C. 2,370,000, W.B.C. 4,800, Hgb. 40 per cent. Gastric contents showed no free hydrochloric acid.

Patient put on rigid Minot's regime-diet, and hydrochloric acid.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	Hb.
2/7/27	2,370,000	4,800	40%
2/9/27	2,320,000	4,600	42%
2/11/27	2,580,000	5,000	38%
2/14/27	3,090,000	4,400	40%
2/16/27	3,010,000	5,200	40%
2/18/27	3,090,000	5,000	40%
2/21/27	3,840,000	6,200	48%
2/23/27	3,220,000	5,800	44%
2/25/27	3,400,000	6,000	50%
2/28/27	3,660,000	6,200	46%
3/2/27	3,720,000	5,400	48%
3/4/27	3,890,000	5,400	50%
3/7/27	3,980,000	5,600	56%
3/9/27	3,980,000	6,000	52%
3/11/27	3,990,000	6,800	52%
3/13/27	3,990,000	6,800	60%
4/15/27	4,480,000	6,400	80%

Symptomatic improvement very rapid, appearance improved, strength returned, red blood count increased gradually, and on discharge, March 13, 1927 after thirty-four days in hospital, red blood count was 3,990,000. On April 15, 1927, R.B.C. 4,480,000, W.B.C. 6,400, Hb. 80 per cent.

Mrs. E. B. Age: 42 years.

Was seen on the 24th of April, 1926 with the usual signs of pernicious anemia, exhaustion, swelling of feet, mucous membranes pale, and sore tongue. R.B.C. 3,360,000, W.B.C. 6,000, Hb. 50 per cent. Patient was placed on Minot diet.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	Hb.
5/22/26	3,320,000	6,200	70%
6/19/26	3,060,000	7,000	68%
7/24/26	3,180,000	7,400	60%
9/4/26	3,200,000	8,600	70%
10/9/26	3,840,000	6,800	70%

At this time patient was placed on Minot diet.

DATE	R.B.C.	W.B.C.	Hb.
11/6/27	4,704,000	4,800	70%
1/8/27	4,720,000	7,800	85%
3/12/27	4,804,000	8,400	80%

In this patient it is seen that the response to medication prior to the use of the high protein diet was very slow. The improvement with the dietary management of the case however, was at once noticeable.

SECONDARY ANEMIA

Mrs. L. M. Age: 27 years.

Admitted to hospital October 28, 1923. Has had recurrent attacks of rheumatic fever over a period of years, chorea in childhood. Came into hospital because of recurrence of rheumatic fever, and early symptoms of heart failure.

Patient showed marked pallor of skin and mucous mem-

branes, several swollen tender points. Signs of early congestive heart failure. Heart shows signs of mitral stenosis, and insufficiency. Blood count on admission: R.B.C. 3,320,000, W.B.C. 5,100, Hgb. 70 per cent. Put on Minot's diet; no hydrochloric acid. Specific treatment for rheumatic fever.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	Hb.
10/28/26	3,320,000	5,100	75%
11/6/26	3,720,000	8,700	65%
11/10/26	3,380,000	8,200	74%
11/12/26	4,220,000	6,800	72%
11/15/26	4,970,000	7,000	73%
11/24/26	5,520,000	7,800	75%

Red blood count went up quite rapidly, patient's general condition improved. Discharged in good condition, November 29, 1926. R.B.C. on discharge 5,520,000, Hgb. 80 per cent. Stay in hospital, twenty-seven days.

SECONDARY ANEMIA

Mrs. M. S. Age: 37 years.

Patient entered hospital December 9, 1926 with history of bleeding from hemorrhoids for two months, or more. Had lost weight. On admission was very weak, pale, had frequent dizzy spells. Dyspnea, and palpitation on exertion, numbness, and tingling of extremities, swelling of ankle.

On admission R.B.C. was 2,470,000, with Hgb. 42 per cent. Smear showed changes of a marked secondary anemia. Patient put on Minot's diet with hydrochloric acid. In spite of some continued bleeding from rectum, the red blood count went up to 3,680,000 on January 8, 1927. Hemorrhoidectomy performed January 10, 1927. Patient discharged January 12, 1927 with R.B.C. of 3,790,000. Felt quite well on discharge.

BLOOD PICTURE

DATE	R.B.C.	Hb.
12/9/26	2,470,000	42%
12/10/26	2,370,000	46%
12/15/26	2,630,000	46%
12/18/26	2,840,000	52%
12/22/26	3,150,000	54%
12/28/26	3,630,000	50%
12/31/26	3,290,000	58%
1/4/27	3,140,000	52%
1/8/27	3,680,000	54%
1/12/27	3,580,000	50%
1/14/27	3,790,000	50%

Mrs. L. H. Age: 46 years.

Patient admitted to hospital December 12, 1926. She was suffering from advanced congestive heart failure, showed marked oedema, was vomiting a great deal, and was extremely weak. Could take no diet at first. With digitalization, and diuretics, patient's condition improved. However, R.B.C. which was 2,570,000 on admission, was only 2,650,000 on December 23, 1926, thirteen days after admission. On latter date, Minot's regimen was started with hydrochloric acid dr. 1, T.I.D. General condition improved still more rapidly, and red count mounted rapidly, being 4,140,000 on January 27, 1927, thirty-five days after introduction of the diet, and forty-nine days after admission to hospital.

BLOOD PICTURE

DATE	R.B.C.	HGB.
12/13/26	2,570,000	45%
12/23/26	2,650,000	50%
12/27/26	3,190,000	60%
12/31/26	3,200,000	62%
1/4/27	3,690,000	48%
1/10/27	3,480,000	45%
1/13/27	3,820,000	65%
1/12/27	4,040,000	60%
1/20/27	3,750,000	65%
1/24/27	4,080,000	70%
1/27/27	4,140,000	75%

Mrs. J. F. Age: 42 years.

Patient was seen on October 2, 1926 with a history of exhaustion, weakness of arms, constipation, some pain in left side of chest. Menstrual periods lasting seven or eight days; appetite poor.

The only positive sign was a slight enlargement of the heart. The pelvic examination which was done by Dr. James R. Miller of Hartford was negative for fibroid or malignancy. Blood Wassermann negative. Nonprotein nitrogen 22 mgs. in 100 cc. of blood. Blood sugar 105 mgs. in 100 cc. of blood. Urine—1018 acid clear, albumin and sugar negative. R.B.C. 3,200,000, W.B.C. 6,000, Hgb. 50 per cent, polymorphonuclears 67 per cent, large lymphocytes 9 per cent, small lymphocytes 24 per cent.

Diagnosis: Secondary anemia.

Artificial menopause was produced with radium.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	HGB.
12/22/26	2,940,000	5,400	45%
Placed on Minot diet.			
1/20/27	3,800,000	7,000	55%
2/22/27	4,456,000	6,800	70%
3/24/27	4,712,000	8,000	78%

Clinically the patient has improved very much. She looks better. Color is very much better.

J. S. Age: 14 years.

Patient was admitted to hospital on December 30, 1926. The chief complaint at this time was respiratory embarrassment. He coughed some. The past history excepting the usual children's diseases was negative. He was undernourished. The positive findings were enlarged cervical axillary and inguinal glands, spleen and liver were palpable, there was a soft systolic murmur at the apex. An x-ray of the chest showed massive mediastinal enlargement. The blood Wassermann was negative. Blood sugar 88 mgs. in 100 cc. of blood. Non-protein nitrogen 20.5 mgs. in 100 cc. of blood R.B.C. 3,820,000, W.B.C. 20,000, Hgb. 60 per cent, polymorphonuclears 74 per cent, small lymphocytes 19 per cent, large lymphocytes 7 per cent. On January 1, 1927, one of the enlarged axillary glands was removed. Biopsy report showed typical picture of Hodgkin's disease. The patient had several severe attacks of respiratory embarrassment. At intervals the temperature was elevated for several days. The patient has gradually grown worse. The following blood picture before and after Minot's diet is outlined below.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	HGB.	POL.YS.	LRG.	SM.
			%	%	%	%
12/30/26	3,820,000	20,000	60	74	7	13
1/5/27	3,460,000	17,200	70	87	8	5
2/16/27	2,980,000	15,000	70	74	11	15

At this point the patient was placed on a rigid Minot diet.

DATE	R.B.C.	W.B.C.	HGB.	POL.YS.	LRG.	SM.
			%	%	%	%
2/19/27	2,990,000	17,000	50	84	10	6
2/28/27	3,410,000	28,600	60	85	6	9
3/7/27	3,460,000	17,400	50	85	7	8
3/15/27	3,810,000	14,000	70	80	11	9
3/19/27	4,100,000	17,000	80	80	12	8
4/1/27	4,350,000	24,600	60	90	6	4

The very unusual thing about this case is that while the condition of this patient has grown worse, the blood picture under Minot's diet has improved very much.

ATYPICAL SECONDARY ANEMIA

W. S. Age: 67 years.

Patient was seen on February 1, 1927 with the usual history of tiring easily, occasional attacks of dizziness. Past history negative except for rheumatism 20 years ago. The positive physical signs were: Skin and mucous membranes pale, soft systolic murmur at apex of heart, heart irregular. Spleen and liver palpable. Left inguinal hernia. Wassermann negative. Blood sugar, 120 mgs. in 100 cc. of blood. Non-protein nitrogen, 28 mgs. in 100 cc. of blood. R.B.C. 3,872,000, Hgb. 40 per cent W.B.C. 8,800. Polymorphonuclears 56 per cent. Large lymphocytes 11 per cent, small lymphocytes 35 per cent.

The patient was placed on Minot's diet, and dilute hydrochloric acid.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	HGB.
2/22/27	3,900,000	8,400	60%
3/17/27	4,100,000	7,800	60%
3/25/27	4,160,000	7,000	65%
4/8/27	4,300,000	8,200	75%
4/29/27	4,456,000	11,200	70%

The smears showed changes in the shape and size of the red cells, and marked achromia.

Mrs. S. R. Age: 46 years.

Past history: Patient had gastro-enterostomy done in 1912. Hysterectomy for fibroid in 1917. She was seen for present condition on November 20, 1926. Her chief complaint was great weakness.

BLOOD PICTURE

DATE	R.B.C.	W.B.C.	HGB.
12/28/26	4,040,000	6,600	70%
1/18/27	4,504,000	7,200	68%
3/10/27	4,260,000	6,000	62%
4/11/27	4,800,000	8,600	75%

The positive findings were cyanosis of lips, finger tips, throat, and tongue. R.B.C. 3,352,000, W.B.C. 5,400, Hb. 68 per cent. A definite change in the shape and size of the red cells was noted. Spectroscopic examination showed no

methemoglobin. A diagnosis of pernicious anemia was made, and patient was placed on Minot diet.

The patient has improved very much. Cyanosis and weakness disappeared. The patient is feeling very much better.

CONCLUSIONS

1. While it is true that the number of cases in this series is certainly limited, the uniform success obtained in bringing up the blood picture together with the clinical improvement can not be overlooked.

2. The Minot and Murphy regimen seems to have a very definite place in the treatment of anemias, either primary or secondary. It is noteworthy that improvement in the blood picture is slow and gradual for the first three weeks or so, but thereafter, in favorable cases, it progresses rapidly.

3. It is probable that the real value of the treat-

ment is due to the presence of iron and vitamin E in liver.

4. The economic question seems to have been solved by this method of treatment. This is particularly true in those cases which formerly required repeated transfusions.

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HEMOLYTIC ANEMIA OF PREGNANCY WITH REPORTS OF CASES

THOMAS P. MURDOCK, M.D., *Meriden*

HEMOLYTIC anemia of pregnancy is a specific form of anemia, occurring usually during the latter months of pregnancy, or during the puerperium.

Despite the fact that these women frequently show a definite blood picture, and the clinical manifestations of primary anemia, it would seem that this disease is a specific type of anemia of pregnancy, because if the patient survives the acute attack, the blood picture usually returns to normal, and apparently remains so. This latter fact definitely removes the disease from the heading of primary anemia.

The literature on the subject is not voluminous, and much work remains to be done. This is particularly true as to the etiology.

Very little is known as to the etiology of the subject. Adler¹ believes that there is a predisposition to the disease. This is doubtful in view of the fact that in about all of the cases reported, no previous

history of anemia could be obtained, and many of the people have had no recurrences.

Rowland² believes that there is produced in the ectodermal cells of the chorion, a synctial hemolysin.

Larrabee³ reported seventeen cases of anemia occurring in pregnancy. Seven of these had the blood picture of secondary anemia, eight had the blood picture of pernicious anemia, one the blood picture and clinical signs of aplastic anemia, and one atypical anemia.

Rowland² reported two cases in 1924. Both of these cases gave the true blood pictures and clinical signs of pernicious anemia.

Hoskins⁴ reported a case in February of this year. The clinical signs and blood picture in his case were those of pernicious anemia. He believes the condition to be very rare in England, and not uncommon in Northern India.

The diagnosis of the condition is not always easy.

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The anemia from postpartum hemorrhage or the anemia secondary to any obstetrical hemorrhage should not be confused with this condition.

The anemias associated with the toxemias of pregnancy probably present the greatest obstacles to the proper diagnosis of hemolytic anemia of pregnancy. However, blood chemistry determinations, retinal changes, and urinary findings will be helpful in eliminating the toxemias of pregnancy.

Some patients suffering from hemolytic anemia of pregnancy have slight elevations of temperature, and the possibility of puerperal sepsis must be considered. Subacute bacterial endocarditis⁵ with its associated anemia must be ruled out. Blood cultures in both of these conditions will be helpful.

Given a case of progressive anemia, either with the blood picture of primary anemia, or one approaching it, and one which cannot be classed as secondary to any other cause, hemolytic anemia of pregnancy should be borne in mind. If to these facts are added the history of an easy or spontaneous labor with little or no bleeding, the diagnosis should be easily arrived at.

On the whole the outlook in this condition is good. Certainly it is not as bad as the older writers believed it to be. If the patient recovers from the so-called acute or active stage of the disease, the outlook for complete recovery is good. However, there seems to be a difference of opinion as to the possibility of recurrences of the disease with subsequent pregnancies. I believe that there is a very great probability of the disease recurring during subsequent pregnancies, and that this possibility should be given very serious thought by obstetricians. In one of the cases (Mrs. D.) reported below, it seems probable that the illness of 1920 occurring during pregnancy and following delivery, while undiagnosed as such, was hemolytic anemia, and that the attack in 1926 during a subsequent pregnancy was a recurrence.

The treatment until the present time has been transfusion in the severe cases. In the milder cases, many of them will respond to the administration of iron and arsenic, and the usual methods of treatment of mild anemia.

I am sure that in the future many of these cases will be successfully managed with the Minot and Murphy⁵ high nucleo-protein diets. In one of the cases (Mrs. P.) reported below, the patient was placed on a high nucleo-protein diet after leaving the hospital, and the response was very gratifying.

It would seem that this plan of treatment should take a prominent place in the management of these cases in the future.

REPORTS OF CASES

Mrs. P. Age: 32 years. Primipara.

Family history: Father, mother and three sisters living and well.

Past history: Negative.

Patient was delivered by Dr. J. E. Stoddard on January 18, 1926. Labor was long, and difficult, and forceps were used in delivery. Twelve hours later, patient had slight elevation of temperature. Patient was seen in consultation with Dr. J. E. Stoddard on February 11, 1926, twenty-four days after delivery. She complained of feeling tired, and of some headache. Face slightly oedematous, mucous membranes pale, pulse rapid. R.B.C. 2,580,000 W.B.C. 8,400 Hb. 50 per cent. Polymorphonuclears—56 per cent. Small lymphocytes—40 per cent. Large lymphocytes—4 per cent. Blood culture negative. Urine—1010, acid, clear, albumin small precipitate, sugar negative, occasional white blood cell. A diagnosis of hemolytic anemia was made, and patient was placed on iron and arsenic.

Subsequent blood counts were as follows: June 10, 1926, R.B.C. 4,032,000 W.B.C. 8,000 Hb. 70-80 per cent. August 12, 1926, R.B.C. 4,704,000 W.B.C. 4,600 Hb. 75 per cent. Patient was placed on a high nucleo-protein diet. The blood count on September 2, 1926, was R.B.C. 5,028,000, W.B.C. 7,800, Hb. 75 per cent. November 2, 1926, R.B.C. 5,110,000, W.B.C. 7,600, Hb. 90 per cent. Reports from the patient since that time are that she is doing well, and has not had any symptoms of recurrence.

Mrs. D. Age: 26 years. Multipara.

Family history: Father, mother, brother and sister living and well.

Past history: Influenza in 1918. Patient gave history of kidney trouble during first pregnancy. This occurred in 1920. Following delivery, patient was anemic and this condition cleared up very slowly. Blood count which was done at this hospital, showed R.B.C. 2,400,000, W.B.C. 5,200, Hb. 40 per cent. It was believed at that time that patient had an anemia associated with a kidney disease. In all probability this was a true hemolytic anemia of pregnancy.

Patient was delivered on March 6, 1926 by Dr. I. S. Otis. On March 18, 1926, when patient was seen in consultation with Dr. Otis, she complained of exhaustion, headache, and ringing in ears. Patient was pale, head oedematous, conjunctivae, tongue, lips, and pharynx pale. There was a soft systolic murmur at the apex, blood pressure 110 over 60, liver and spleen palpable, R.B.C. 1,665,000 W.B.C. 6,600, Hb. 40 per cent. A diagnosis of hemolytic anemia of pregnancy was made, and transfusion advised. During this procedure, the needles became obstructed, and the transfusion was very unsatisfactory. On March 21, 1926 the blood count was, 2,240,000, W.B.C. 6,800, Hb. 50 per cent. Polymorphonuclears 66 per cent. Small lymphocytes 27 per cent, large lymphocytes 4 per cent, transitionals 3 per cent. The patient was placed on iron and arsenic, and was discharged on April 10, 1926. The blood count at this time was 3,300,000, W.B.C.

6,800 Hb. 60 per cent. A report since discharge is that she is doing very well.

Mrs. E. M. Age: 32 years. Multipara.

Patient was seen in consultation with Dr. H. L. Peters, and Dr. H. W. Waterhouse. The patient complained of weakness, ringing in ears, dizziness. She was taken ill on December 12, 1924 with what was thought to be an influenzal infection. She was in the ninth month of her pregnancy. At that time she complained of weakness, headache, and dizziness. She was afebrile. On January 17 she was delivered of a baby. The labor was short, and with minimum amount of bleeding. Her convalescence was slow.

When examined on February 13, 1925 she was pale, mucous membranes were pale, there was a systolic murmur at the apex, the liver and spleen were palpable. The Wassermann was negative. The R.B.C. was 1,600,000 W.B.C. 5,200, Hb. 33 per cent. There was a change in the size and shape of the red cells.

A diagnosis of hemolytic anemia of pregnancy was made. The patient was transfused, but the response was not marked, and transfusion was repeated one week later. Her condition improved at once.

A blood count which was done on March 14, 1925 showed R.B.C. 4,100,000 W.B.C. 6,200 Hb. 80 per cent. May 19, 1925, R.B.C. 4,944,000 W.B.C. 6,600 Hb. 85 per cent. July

9, 1925, R.B.C. 5,464,000 W.B.C. 6,200, Hb. 95 per cent. February 1, 1927, R.B.C. 5,318,000 W.B.C. 11,100 Hb. 90 per cent.

CONCLUSIONS

1st. Hemolytic anemia is a specific anemia of pregnancy with the blood picture resembling the blood picture of pernicious anemia.

2nd. The condition is likely to recur with succeeding pregnancies.

3rd. High nucleo-protein diets should be given a thorough trial in the management of this disease.

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UNDULANT FEVER IN CONNECTICUT WITH REPORTS OF THREE CASES

THOMAS P. MURDOCK, M.D., and W. E. HALL, M.D., *Meriden*

UNDULANT fever, known also as Malta fever, Mediterranean fever, and Gibraltar fever, is characterized by continued fever, or fever with short remissions and relapses, neuralgic pains, joint swelling, orchitis, and profuse perspiration.

DISTRIBUTION

Text books state that undulant fever has not been reported north of latitude 45° N. or south of 40° S. latitude. It is known to have occurred in every part of the island of Malta.

Orr and Huddleson¹ have reported sixteen cases of undulant fever occurring in Michigan from June 1926 to October 1927. Cases of undulant fever due to the *Bacillus abortus* have been reported in New York State by Carpenter.²

Keefer³ reported a case of Malta fever occurring in Baltimore, Maryland, in 1922.

Sensenich⁴ and Giordano recently reported seven

cases of *Brucella abortus* infection occurring in Indiana.

Up to the present time there have been sixteen cases⁵ reported in the State of Connecticut. Of these, three have occurred in Meriden, Conn.

ETIOLOGY

The micrococcus melitensis is the causative organism. It is 3 micromillimeters in diameter, is non-motile and is gram negative. It grows very slowly and is difficult to grow in culture. Acid media should be used, and the culture should be carried through for eleven or twelve days. Since it has been recognized that there is a very close relationship between the *Bacillus abortus* and the *Micrococcus melitensis*, the bovine source of infection has added to the seriousness and importance of this disease.

In 1914 Kennedy⁶ testing goat's milk for agglutinins specific to the micrococcus melitensis, found

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the control cow's milk gave a positive result. Goat's milk has been the chief offender. It is thought that the larger number of cases have come from infected cattle. This seems to us to be very doubtful. McAlpine and Mickle⁷ have reported on their investigations of a very large number of dairy herds in Connecticut. Of this large number 90 per cent were shown to be harboring the bacillus abortus. If this is so why are not more people infected with undulant fever? Knowing that cattle can be infected by the porcine strain, isn't it much more likely that only the cattle harboring the porcine strain, can transmit the disease to man?

The incubation period is thought to be about fourteen days, although this is difficult to determine.

IMMUNITY

There is some difference of opinion concerning immunity, but one attack is thought to confer protection from subsequent infection.

SYMPTOMS

The disease begins insidiously. The patient usually feels well in the morning and on toward evening complains of feeling hot and tired. The temperature in the morning is usually under 100° and in the evening ranges between 100° and 104°. This is usually followed by marked perspiration. Constipation is a common symptom. Neuralgic pains are usually complained of by the patient. Later on the usual symptoms of a secondary anemia are seen.

MORTALITY

The mortality is not high. About one to three per cent of cases are fatal. The duration of disease is usually about four or five months, although it may be considerably more or less.

DIFFERENTIAL DIAGNOSIS

Frequently diagnosis by exclusion is necessary. The diseases most often confused with undulant fever are typhoid, tuberculosis, subacute bacterial endocarditis, and aestivo-autumnal malaria. Blood culture and Widal will usually suffice to separate typhoid. The clinical picture and blood culture will aid in the diagnosis of subacute bacterial endocarditis. Tuberculosis can be ruled out by physical examination, sputum, and x-ray; aestivo-autumnal malaria, by demonstrating the parasite in the blood smears.

DIAGNOSIS

Diagnosis is accomplished by the history of un-

dulating fever, accompanied by pains in the joints, and by recovering the organism in the blood culture. At times this latter is very difficult. With a clinical picture of undulant fever, and with a positive agglutination of the micrococcus melitensis up to at least 1:200, one is justified in making a diagnosis of undulant fever. This is particularly true when the simulating diseases can be ruled out.

A cutaneous test for the diagnosis of this disease has been suggested by Oliver and Massot.⁸ It consists of the injection of 1/10 to 1/20 cc. of a filtrate of micrococcus melitensis into the skin. In positive cases there is no general reaction, but at the site of injection there is local oedema, redness, and pain appearing between six and twenty-four hours.

TREATMENT

The treatment is largely symptomatic. In the chronic cases, vaccines made from the micrococcus melitensis and para-melitensis have been advised.

PROPHYLAXIS

Removal from the diet of all suspicious foods is indicated, particularly goat's milk and its by-products and also suspected cow's milk.

CASE REPORTS

Case 1. P. R. Age 32 years. Catholic clergyman. The patient was first seen on December 29, 1927. The family history was unimportant.

Past history: Fractured right leg ten years ago. Three years ago was in hospital with rheumatism which cleared up following extraction of teeth.

Present illness: Patient complained of sore throat, pain in neck and cough. This has been going on for the past four days. The temperature was 100°.

Physical examination: Pupils equal and react to light and accommodation. Mucous membrane of nose and throat inflamed. Cervical glands slightly enlarged. Thyroid normal. Heart regular, no murmurs. Heart not enlarged. Bl. Pr. 116-60. Lungs negative. Liver and spleen not palpable. No tenderness in abdomen. Right leg ¾" shorter than left. Knee jerks normal. Babinski and Koenig negative.

The temperature returned to normal on January 2nd/28 and remained so until January 11th/28. On this date it went up to 102°. This elevation continued for about four weeks. He was admitted to the Meriden Hospital on February 7th/28th. The only additional signs on physical examination were râles in the bases of both lungs, and some general weakness. During his stay in the hospital, he had two remissions when the temperature came down to 99° and remained so for about three days when it again became elevated. He was discharged from the hospital on April 6th/28. His temperature had been normal for one week, and has remained so since then.

Laboratory findings: Urine—1018 ac.cl. albumin negative.

Sugar negative. Erythrocytes 4,400,000. Leucocytes 10,000: polys—65 per cent, large—12 per cent, small—23 per cent. Blood culture January 14th/28, January 23rd/28, and February 3rd/28 were negative. These were all taken at the height of fever. Agglutination for typhoid and para-typhoid A and B were negative. Smears for malarial parasites were negative. The blood in dilutions up to 1:300 agglutinated the *alcaligines melitensis*. X-rays of chest were negative. Repeated examination of sputum were negative for tubercle bacilli.

Diagnosis: Undulant fever.

COMMENT

It will be seen that this patient had three relapses from December 29, 1927, until his discharge from the hospital on April 6, 1928. The *alcaligines melitensis* was agglutinated by the serum in dilution of 1:300.

Case 2. Mr. F. H. Age 44 years, Married, no children. Salesman. Territory was through the west and southwest. The patient was seen in consultation with Dr. J. D. Eggleston on January 16th/28. The family history and past history were unimportant. He had been ill for three weeks. The chief complaint was elevation of temperature, usually during the afternoon or early evening. The other symptoms were weakness, and occasionally pains in the legs. Subsequently a history of inordinate craving for cheese was obtained.

Physical examination: The pupils react to light and accommodation. Conjunctivae pale. There is some bridge work in mouth. Nose negative. No tenderness over sinuses. No cervical glandular enlargements. Thyroid normal. No facial palsies. Heart sounds are soft. There are no murmurs. The heart is not enlarged. Bl.Pr. 127-70. Lungs—rales in the bases of both lungs. Arms are a little flabby. There are two small petechiae on the left hand in back. Abdomen—liver and spleen just palpable at the costal margins. Back is negative. Legs not edematous. Knee jerks normal. Babinski and Koenig negative.

Impression: Subacute bacterial endocarditis.

Laboratory findings: Urine—1028 ac. cl. albumin negative. Sugar questionable. Erythrocytes, 3,750,000. Leucocytes, 10,000. Hb.—70 per cent. Polys—63 per cent: large mononuclears—14 per cent. Small mononuclears—30 per cent, Eos—3 per cent. Non-protein nitrogen—33 mgs. in 100 cc. of blood. Blood sugar—166 mgs. in 100 cc. of blood. Blood Wassermann negative. Blood culture negative. The agglutination for typhoid, and para-typhoid A and B were negative. Blood smears for malarial parasites negative. The serum agglutinated the *alcaligines melitensis* in dilutions up to 1:300. The radiograms of teeth, sinuses and chest were negative. The blood culture was repeated on January 27th/28. This was taken at the height of fever but no growth could be obtained. The temperature returned to normal on February 15th/28 and remained so.

Diagnosis: Undulant fever.

COMMENT

The noticeable facts about this patient were his craving for and his eating of large amounts of

cheese. The territory in which he traveled would include some of the states which have reported cases of undulant fever.

Case 3. Mrs. R. T. Age 43 years. Housewife, married, two children. No miscarriages.

The past history is negative excepting some nervous conditions about six years ago, which quickly cleared up.

The patient consulted us on January 20th/28. She complained of pains in lower part of her back and thighs for the past two weeks. For one week she has known that she had an elevation of temperature. This ranged from about 100° in the morning, to 103° in the late afternoon or evening. When questioned closely, she believed from her symptoms that she must have had an elevation of temperature about one month ago, with a subsequent remission.

Physical examination: The pupils are equal and react to light and accommodation. The nose and throat are negative. There are some suspicious teeth. There are no cervical glandular enlargements. The thyroid is normal. The heart is not enlarged. There is a murmur at the apex, systolic in time. The blood pressure is 114-70. The liver and spleen are not palpable. There are no masses felt in the abdomen. Rectal and vaginal examinations are negative. The knee jerks are normal. The Babinski and Koenig are negative.

Laboratory findings. Urine—1020 ac. turbid, albumin negative, sugar negative. Microscopical—occasional pus cell. No clumping. Erythrocytes, 4,800,000. Leucocytes—8,800: polys—65 per cent, large mononuclears—11 per cent, small mononuclears—23 per cent, eosinophiles—1 per cent. Blood Wassermann negative. Non-protein nitrogen—25 mgs. in 100 cc. of blood. Blood sugar—110 mgs. in 100 cc. of blood. Blood culture negative. Agglutination for typhoid and para-typhoid A and B were negative. Blood smears for malarial parasites negative. The blood agglutinated the *alcaligines melitensis* in dilutions up to 1:300. X-ray of teeth showed some suspicious teeth.

Diagnosis: Undulant fever.

Blood cultures were taken on January 20th/28 and February 1st/28 at the height of fever, but no growths were obtained. The patient had two remissions between January 20th/28 and March 10th/28 with relapses. Since March 27th/28 the temperature has remained normal.

COMMENT

It would appear that undulant fever due either to the *bacillus abortus* or to the *micrococcus melitensis*, is more widespread than was formerly thought. With the number of cases which are being recognized in Connecticut, it is probable that this disease occurs in areas not heretofore considered.

The question of the habitat of the causative agents we are sure will demand further investigation. If the *bacillus abortus* is being harbored in the udders of cattle, why are not more people infected? Are the porcine and equine types more frequently found than the bovine? These are questions which must be answered.

Signs and symptoms of bronchitis as characterized by cough and râles in the bases of both lungs, were symptoms common to all three patients reported in Meriden.

CONCLUSIONS

1. Undulant fever is probably more common in Connecticut than was heretofore thought. Three cases are reported in Meriden, Conn.

2. In all three cases the serum agglutinated *Alcaligenes melitensis* in dilutions up to 1:300.

3. Further investigation as to the habitat of the causative organisms and the avenues of infection is warranted.

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AN ANALYSIS OF TWENTY-FIVE HUNDRED BLOOD WASSERMANN REACTIONS

THOMAS P. MURDOCK, M.D., and W. E. HALL, M.D., *Meriden*

IT has been our custom for a number of years to do blood Wassermann reactions routinely on all of our private patients. We consider this an essential precautionary measure with full realization of the fact that a negative result is not necessarily final and totally exonerating. The necessity for this attitude has been impressed upon us frequently. Just recently a patient whom we had examined and who was asymptomatic at the time and on whom we had not done a blood Wassermann reaction was seen by another physician some time later with rather prominent signs of tertiary syphilis. It occasionally happens that the syphilitic when seen is asymptomatic. When this happens, despite the fact that the patient is symptom free, the physician is very likely to be discredited in the event that the patient is later proved syphilitic.

All of the Wassermann reactions reported here were done at the State Laboratory at Hartford, Connecticut, or at the laboratory of the Meriden

Hospital or at the Brady Memorial in New Haven, Connecticut.

There was a total of 1942 patients on whom the Wassermann reaction was run. On this number of patients there were done 2,500 Wassermann reactions. This is explained by the fact that on many patients with suspected syphilis the complement-fixation test was done in at least two laboratories, or was checked in another laboratory later on; also following treatment the results were checked with blood Wassermann reactions. On some patients with positive blood Wassermann reactions as many as 15 tests have been done.

Of the 1,942 patients subjected to serum examination, there were 106 found to be positive. This is 5 per cent of the actual number of persons examined. This seemed to us to be a very low percentage, despite the fact that the cases were not selected and that the Wassermann reaction was run routinely. When it is considered that a very large percentage

of the people examined consulted us for some internal medical problem, it seemed likely that we would obtain a higher percentage of positive reactions.

In all there were obtained 274 positive and 2,226 negative reactions. This gives 12 per cent positive on the total number done.

There were 1,102 males and 840 females. The number of males reacting positively was 77 or 6 per cent. The number of females reacting positively was 29 or 3 per cent.

Proportionately there were about twice as many positive reactions in the males as there were in the females.

The oldest patient on whom a Wassermann reaction was run was eighty-two years; the youngest two and one-half years. The oldest male on whom a positive reaction was obtained was sixty-eight. The oldest female on whom a positive reaction was obtained was fifty-nine. The youngest male on whom a positive was obtained was seventeen. This patient had acquired syphilis with secondary manifestations. The youngest female was eighteen and had congenital syphilis.

There were 733 between the ages of fifteen and thirty, 406 between thirty and forty, 313 between forty and fifty and 465 over fifty; of this number the positives obtained between fifteen and thirty were 35 or 5 per cent; between thirty and forty, 23 or 5 per cent; between forty and fifty, 22 or 6 per cent; and over fifty years, 24 or 5 per cent. Under fifteen there were 2 positives obtained.

The noticeable thing about this tabulation is the uniformity of percentage of incidence for all ages over fifteen years. There was a very slight increase in the series between forty and fifty years.

Of the 106 on whom positive blood reactions were obtained, 18 are dead. The causes of death were, suicide 2, both of these were paretics; tabes, 3; paresis, 5; cerebral syphilis, 3; pneumonia, 2; tuberculosis, one; accident, 2.

Of the 18 patients who are dead, 13 or 72 per cent died directly or indirectly of syphilis of the central nervous system. It would seem from this that the mortality from syphilis is very largely due directly or indirectly to syphilis of the central nervous system.

Fifty-seven are known to be living and 32 were lost track of. The status of the living is about as

follows: 31 are clinically negative and are asymptomatic. Of these 31, 8 are also serologically negative, 13 have tabes, 3 have paresis, 5 have syphilitic heart disease, one has syphilis of the liver, 2 have diabetes, 2 have cerebral syphilis. Of the tabetics, 8 are asymptomatic, 2 are having very severe symptoms and 3, milder symptoms. Of the 2 cases of cerebral syphilis, one is bedridden and one now is free from symptoms and is under treatment. Of the 3 patients with syphilitic heart disease, 2 are able to carry on reasonably well, while one is beginning to show definite evidence of beginning congestive heart failure. The patient with syphilis of the liver is now practically asymptomatic. The 2 cases of so-called diabetes might well be classed as syphilis of the pancreas, one has only a moderate elevation of blood sugar with sugar in the urine, the other has glycosuria but no elevation of blood sugar.

It will be seen from the above that, at the present time, of the 57 patients living, 18 have syphilis of the central nervous system. This is about 31 per cent, a figure somewhat higher than that reported by other observers. The critical view to be taken from this report, however, is the fact that of the 26 clinically active, and serologically positive, 18 or 69 per cent have syphilis of the central nervous system.

This is a situation that is hard to explain. It has been explained by many observers as being due to the inadequate use of the arsenicals. In this series we know that such explanation cannot apply. Many of these people did not know of their syphilis until they were examined and had no treatment of any sort. Many of them with syphilis of many years' duration were treated with the iodides and mercury. Some had very thorough treatment with the arsenicals and bismuth. In the few cases which we have seen early and have managed ourselves, either before the clinical manifestations of syphilis of the central nervous system or shortly after their inception, we have treated thoroughly with arsenicals and with bismuth. Of course, it is true that the syphilitic patients who get into most serious difficulty from their syphilis are those who develop cardiovascular syphilis or syphilis of the central nervous system. It would seem to us that the only fair way to handle these patients, and to establish their position in good time, is to advocate lumbar puncture early in the disease and to manage them from this viewpoint.

It is now generally accepted that about 25 per cent of syphilitics develop syphilis of the central

nervous system; of those who do develop the condition, as shown by the spinal fluid, 25 per cent do so in the first six months of the disease.

Our small percentage of serologically negative or recovered cases is explained by several justifiable reasons. First, the social factor is a very great one. Many of these people are married and this must be taken into consideration. The management of syphilis in married people requires a great deal of care and tact. Frequently it is necessary for the clinician to equivocate or deliberately prevaricate repeatedly in order that the home may be saved. It is necessary to treat each individual case as it presents itself. Frequently this requires inadequate treatment. This is particularly true if the patient is without symptoms. In our opinion no great harm is done by under-, rather than overtreating the asymptomatic syphilitic. Secondly, by the time when we have seen the patients, the disease is usually of many years' duration. It has been our experience that the blood of these people seldom, if ever, becomes serologically negative. Finally the old axiom of medicine that one should treat the patient rather than the disease must be considered. As an example of this procedure, we have in mind a woman eighty years old who was admitted to the medical ward of the Meriden Hospital with bronchopneumonia. Routine examination showed her to be serologically positive for syphilis. She was negative clinically. The check-up in the laboratory at the hospital and in other laboratories confirmed the positive Wassermann reaction. We felt that it would be harmful to attempt to do anything with her syphilis. We believed that any attempt in that respect would simply stir things up and that injury rather than help would result. Here was a woman of eighty years who, we believe, never knew that she had syphilis. This case is not included in the reported series.

From the viewpoint of occupation apparently very little was brought out. Thirty-one were mechanics; 23 were housewives; 17 were merchants; 13 were laborers; 6, manufacturers; 6, clerks; and 10 were of miscellaneous occupations.

In this series there are included 5 negroes. All were examined for some conditions or complaints other than syphilis. In all 5 the Wassermann reaction was strongly positive. In 4 of these we were unable to find any clinical evidence of syphilis.

Aside from the statistical evidence which we submit, there are two interesting points to bring out. First, the great number of denials of primary sores

in this series. Many of these patients denied absolutely having had primary sores. Some, we at once concluded, were not telling the truth. Some were listed as having congenital syphilis and some placed under the heading of undiscovered primary sore, as a chancre within the urethra, and was not known to the patient. Whatever may be the cause or the explanation, the fact remains that many of these people deny the knowledge of syphilis, particularly the knowledge of a primary sore.

Another interesting point is that we have not seen a chancre for a period of three years. Neither have we been consulted for advice about one in this time. Our work is devoted entirely to internal medicine and practically all of our cases of syphilis have been picked up in this line of work. However, it seems strange that we have not seen one in that period. It is possible that these people have consulted general practitioners or syphilographers about this condition. Then again comes the thought that it is possible that syphilis is decreasing. This, we think, is very worthy of thought.

In regard to the marital transmission of syphilis it is interesting to note the large number of instances in which the wife (or husband) of the patient failed to acquire the disease. In this series 59 of the patients were married. On 42 occasions it was possible to examine the opposite member of the family and in 38, he, or she, was negative both clinically and serologically. Four of these 42 apparently had already infected the other member of the family.

We have in mind a series of cases which we saw about five years ago. A prostitute whom we were treating for syphilis continued to ply her trade and infected a young man. He in turn infected his fiancée, despite the fact that he had been warned of the infectiousness of his disease. She developed a chancre of the lip. A short time later, the man's roommate appeared with an indurated area at the first metacarpophalangeal joint of the left hand. This proved to be a chancre. Subsequently a man working in the office with the second girl developed a chancre of the lip. Of these 5 cases three were innocently contracted.

We were satisfied very definitely that 16 people on whom we obtained a negative blood were clinically syphilitic. On all of these people more than one test was run and on all of them it was done in more than one laboratory. Of these 16, three had paresis, four had late secondary manifestations of syphilis, one had a syphilitic liver, two cerebral syphilis, one

syphilitic heart disease with other manifestations of syphilis, and three had tabes. There were two gummas in the series. It will be seen here also that 8 or 50 per cent of the serologically negative cases were cases in which the central nervous system was involved.

Many very interesting sidelights were brought to our attention. In one family the father had tabes and was serologically positive. His primary infection occurred about eighteen months before his marriage. His wife clinically is a tabetic but the spinal fluid is negative and the blood has been repeatedly negative. The oldest child, a girl, is clinically and serologically negative. The next child at twenty years is asymptomatic but is serologically positive. The next two children we have not examined. The second youngest, a boy, is clinically and serologic-

ally positive. The youngest child we have not been permitted to investigate. Why is the oldest child born two and one-half years after the primary infection of the father negative, and why is the second child positive? These are some of the problems continually before medical men and seem to be unanswerable.

CONCLUSIONS

1. Routine blood Wassermann reactions, in our opinion, are justified and warranted even though only a very small percentage of positives are found.
2. In our opinion, syphilis itself is on the decline.
3. We believe that neurologic syphilis is much more frequent than most physicians believe.
4. Only a very small percentage of syphilitics are serologically negative.

MEDICAL EXPERT TESTIMONY

THOMAS P. MURDOCK, M.D., *Meriden*

THE question of medical expert testimony at one time or another has confronted the citizens of the various states. At the present time, in Connecticut, the subject seems to be a compelling one. Most medical men with whom I have talked regarding this subject believe that it is of sufficient importance to warrant action by this society. All of the lawyers whom I have heard discuss this subject have severely arraigned the doctors and the medical societies for permitting the condition to exist. Lay people in general seem to have very little respect for medical expert testimony or for the medical expert.

Wigmore¹ describing expert testimony states, "That sort of capacity which involves not the organic powers, moral and mental, requisite for all testimony, nor yet the emotional power of unbiased observation and statement, but the skill to acquire accurate conceptions may be termed *Experiential Capacity*. The person possessing it is commonly called an expert. This capacity may be obtained by special training or experience, or by both."

It is, in every case, a relative one. That is, relative to the subject, about which the expert is to testify. He may be sufficiently skilled in one subject, and totally unskilled in another. He may for example, be competent to testify that the deceased was asphyxiated, but not competent to say whether or not it was coal gas or water gas which caused death. He may be competent to say that the instrument causing death was sharp, but incompetent to say that the stains on the instrument were human blood.

The methods for obtaining this capacity may be by particularly prearranged training prior to entrance into his special field, or by occupational work which followed some form of previous training. Many famous experts have had very ordinary training prior to gaining experience in this work by occupation. Sometimes one of these methods shades into the other. Either is acceptable.

The calling of skilled medical men to the aid of the court was first recognized in 1345² when the

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court called upon surgeons to determine whether or not the question involved was one for courts or surgeons to determine.

The first recorded expert testimony as such, was in 1620² in the case of *Alsop vs. Kowheel*. This was a case questioning the paternity of a newly born child. In this case a medical expert testified that should a child be born forty weeks and nine days after the death of the husband, the husband might well have been the father of the child.

Mental experts apparently came into being about 1723.³ In the early days in England the question of criminal responsibility was mitigated somewhat by the question of insanity. Prior to 1723 the two kinds of insanity recognized as defenses by the court were idiocy and lunacy. Then came what were called partial and total insanity. This of course closed the gateway to punishment almost entirely. In each case it was established that the partial insanity related directly to the crime involved. In 1780³ an attempt was made to change this principle in the trial of *Hadfield* for shooting at the King in Drury Lane Theatre. The attorney general who prosecuted insisted that to establish a defense of insanity there must be a total deprivation of memory and understanding. It seems to be the impression of historians that in the famous *Bellingham* case in 1812 the pendulum swung way over to the side of the prosecution. *Bellingham* was charged with the murder of *Spencer Percival*. It seems to have been proven that *Bellingham* was wholly incapable of caring for his own affairs and was subject to definite delusions. Despite this he was convicted because of his supposed knowledge of the difference between right and wrong. In 1843³ a great change was made in the previous uncertain standing of the defense of insanity. *Mr. Drummond* was shot by *McNaughton*. *McNaughton* claimed insanity as a defense since he was under the delusion that *Drummond* was one of a number of persons who were following him everywhere. It was disclosed that he was able to carry on business and showed no obvious symptoms of insanity in his ordinary conduct. He was acquitted and thereupon the House of Lords propounded to several judges a questionnaire covering the law of insanity. As the result of this investigation it was finally decided: "To establish a defense on the ground of insanity, it must be clearly proved that at the time of committing the act, the person accused was laboring under such a defect of reason from disease of the mind as not to know the nature and

quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong." In general this is the law today in this country with some modifications in some of the states.

The first recorded case covering the question of expert testimony in Connecticut was reviewed by the Supreme Court in this state in 1812. This was the case of *John Grannis and Martha Grannis his wife, against Pierre E. Braden*. Peculiarly enough, this was also a malpractice suit and, I believe, also the first reported malpractice suit presented to the Supreme Court of this State. In this case the court found for the plaintiffs against the doctor defendant. The complete report of the case might be of interest to you, and I am outlining it for you:

JOHN GRANNIS AND MARTHA GRANNIS HIS
WIFE, AGAINST PIERRE E. BRADEN

MOTION FOR NEW TRIAL

This was an action on the case. It was alleged in the declaration, that for more than six years previous to the 29th day of March 1810, the defendant publicly professed and pursued the practice of physic, surgery and midwifery, in all their different branches; and professed and claimed to possess, full and perfect skill, knowledge and science therein; that on the day and year before mentioned, while the defendant was still pursuing and exercising his profession as above stated, the plaintiffs applied to the defendant and requested him for a reasonable compensation, to deliver said Martha of a child, with which she was then in travail; and that the defendant, in consideration of a reasonable compensation to be paid to him there, undertook to deliver said Martha of the child, in a proper, careful and skillful manner. It was then averred that the defendant, ignorantly, unskillfully and negligently, omitted to deliver said Martha, from the 29th to the 31st day of March, contrary to the well known rules of practice in such cases; that by reason of such omission, and also by reason of his ignorance, carelessness, wickedness and want of skill, in attempting to deliver the child, the said Martha suffered great and unnecessary pain, was exposed to the most imminent danger of losing her life, lost her health, and received lasting and irreparable injuries and wounds; to their damage 5000 dollars etc.

On the trial before the Superior Court, upon the plea of not guilty, the jury found a verdict for the plaintiffs.

In the course of the trial, the plaintiffs offered to prove, by the testimony of *Dr. Cornwall* and others, that the defendant, while attempting to deliver the child, made an incision on its head with a pair of scissors, or some other instrument, and therewith at the time, cut, injured and wounded the mother; and also, that the defendant, for bad management and want of skill, caused a lasting and irreparable injury to the internal parts of the mother, by the violent, unusual, and unwarrantable application of his finger to such parts. The defendant objected to this evidence, on the ground that the facts above specified, were

not alleged in the declaration. But the court overruled the objection, and admitted the evidence.

In the further progress of the trial, the defendant proved by the testimony of the sundry witnesses, that he sustained the reputation of a skilful physician, and that such was his general character; whereupon, the plaintiffs moved to introduce evidence to show, that the defendant, previous to his undertaking the practice of physic, surgery and midwifery, had not been educated or instructed with a view to the practice of such professions; but that he had been employed altogether, in the business of a merchant or grocer, a dancing and fencing master, etc., to the admission of which evidence, the defendant objected; but it was permitted by the court to go to jury.

The plaintiffs also offered evidence to prove, that shortly after the attempt to deliver the child was made, the defendant declared, that said Martha was infected with the venereal disease, and that this was the reason why the delivery was attended with so much difficulty. The plaintiffs, at the same time, proposed to accompany this evidence with other proof, to show that said Martha was not infected with the venereal disease; and thereby to evince, that the defendant treated his patient unskillfully, and through ignorance or negligence in his profession, did not understand her case. This evidence was suffered to go to the jury, but the court, upon its admission, informed the jury that such evidence was not admitted for the purpose of aggravating the damages on account of the slanderous declaration of the defendant, but merely to show the ignorance, and unskillfulness of the defendant in the performance of his professional duty.

The defendant, in support of his professional character, offered to introduce the testimony of Dr. Todd, a skilful and eminent physician, to show that the witness had been called with the defendant, to visit a certain patient, and that the defendant's prescriptions and advice in that particular case, were prudent and correct. This evidence was objected to, by the plaintiffs, and was by the court rejected.

I am of the opinion, therefore, that a new trial ought not to be granted. In this opinion the other Judges severally concurred; excepting Ingersoll, Jr., who having been of counsel in the cause, did not Judge.

New trial not to be granted.

A very frequent criticism which one hears about medical experts is the fact that they will appear for either side. Is this an accurate observation? If this is so, then medicine must get its house in order and I can assure you that I will do all in my power to help make it orderly. However, one must not forget that this is a frequent criticism made by lawyers. Frequently lawyers will make this criticism about certain doctors, but on occasions will employ the same doctors.

A very famous trial lawyer has made the above statement to me and has further said that he would willingly support his statement. I know positively that he has employed the very medical experts he has criticised.

Medicine will not establish a negative defense by saying the same could be said of a great many lawyers, but will attempt, I am sure, to correct the situation as it should be corrected.

The lawyers and other critics of the medical expert must remember that medicine is not, and probably never will be an exact science and because of this there will be many and great differences of opinions. In this connection, the famous case reported by Bartlett⁵ is worth reviewing. In California in 1899 a woman was injured in a railroad accident. She sued the railroad. Three medical experts appeared for the plaintiff and three for the defendant. All had examined the woman. All agreed that she had a uterine fibroid. The experts for the plaintiff testified that it was caused by the accident. The experts for the defendant testified that it was not. The jury found for the plaintiff. She was given a judgment of twenty thousand dollars. Ten days later she was delivered of a still born baby. It would be difficult or impossible to believe that there was any collusion here. Certainly the doctors appearing for the defendant would have been pleased to testify that this was a pregnancy if they had been able to discover it. I bring this out to emphasize again that medicine is not an exact science.

One rarely hears a criticism of religion in general, despite the many sects all arguing on the same fundamental subjects, and all with different approach and different ideas. Who would be bold enough, or foolish enough, to discredit all religion because of the difference of opinion regarding it.

If medicine were to be accepted as a finished and exact product, would not research, investigation and experimentation cease? It would be at a standstill and there would not be need for further study. Again who would be foolish enough to recommend the acceptance of such thought?

I have carefully reviewed the witness books in every court of superior jurisdiction in Connecticut covering the court year from September, 1934 through June, 1935. Some very interesting facts were disclosed. Doctors appeared 677 times. It is quite true, also, that the same doctors appeared several times. Peculiarly enough some doctors who have been thought to do a great deal of court work did not appear as frequently as was expected. In those courts where special records were kept as to appearance before the jury or the court without a jury, the former prevailed as many as nineteen times to one. In other words in one county, damage suits,

in which medical experts testified, were tried before a jury 78 times to four suits that were tried before the court. I could not help but get the impression that there was a definite and probably not a good and honorable reason for this. However, if fault is to be found with this procedure, and I personally believe that such should be the case, I believe the fault is with the lawyers. Perhaps they believe the juries will be more sympathetic than the courts. I have the feeling they believe their special witnesses will make a greater impression on the jury than on the court.

It has become necessary for the medical expert to have a rather large and general knowledge of the law. I believe it is as much a specialty as any of the more highly specialized branches of medicine. As one talks with trial lawyers he gets the impression that the lawyer believes that only truth is brought out on cross-examination. I doubt this very much.

The medical expert, either by special training or experience, has learned to fence with lawyers; he has learned to protect himself against blows below the belt. He has learned to defend himself against brow-beating, coarseness, innuendoes, vulgarities and insults. I firmly believe that I know many medical men of otherwise strong character, who rather than submit to this, would give the desired answer of the cross-examiner and get it over with and out of the way. Is this truth that is brought out? I know many leaders in our profession who avoid going to court for this very reason.

Are the great insurers wholly free from blame in this situation? I doubt it very much. It seems to be the policy and practice of many representatives of insurance companies to attempt to reduce honest bills submitted by medical men. It seems to be the desire of these men to settle these cases always at a reduced rate. They call it "good business." Is it honest and ethical? They say the doctors pad their bills and therefore they must level themselves down to such practice. Could not an honorable settlement be offered without bartering? If such settlement were refused the question could then be taken into Court. Again they say that a certain case has a nuisance value. Since when has honesty had only a nuisance value? Is this ethical? Again I say, I doubt it.

It is accepted, I think, in general that the poor man has not the opportunity, because of lack of funds, to prepare himself as adequately for the Court

as the great corporations. This, I think, is to our everlasting shame.

A representative of a large insurance company with whom I have talked about this distressing situation, feels that the present system is all right. I cannot agree with him.

Lloyd Striker⁶ in his recent book called "Courts and Doctors" states that the witness stand is an ordeal and that the contest of cross-examination is unequal. He gives the usual primer advice to come prepared, be natural, be modest, etc.

Nowhere have I been able to find a book advising the doctor how to protect himself in warding off the abuses and villifications of the cross-examiner. Such a book would I believe, become a first seller, at least amongst medical and other experts. All too frequently it seems the court permits this abuse without reprimand. Recently some of us heard that any abuse of an honest doctor by a lawyer could not destroy that doctor. This seems small recompense for the doctor.

Herzog⁷ frankly makes the statement that he believes the expert will stretch a point to aid the side that he represents. As horrible as this seems to be, I must confess that I believe it is so.

Several writers believe that an expert appearing as a witness should not act as advisor to the lawyer trying the case. I cannot see any great violation of ethics in this procedure.

Emery⁸ condemns the lawyers who appear in court inadequately prepared and frame questions which make it difficult or impossible to bring out medical facts as they should be. I think this statement has much merit and is somewhat responsible for the present situation. He criticizes the expert for accepting retainers in anticipation of future testimony. Isn't it a fact that many ethical lawyers accept retainers for just the same purpose? He also criticizes the expert for partisan testimony and large fees. He does not, however, offer any great or new methods of correction.

Endlich⁹ is particularly critical of the present system because of the method of procuring testimony, the expense involved and anger of partisan viewpoint. All of these seem honest and fair criticisms, but here again no concrete method of correction is offered.

Friedman¹⁰ writing on expert testimony is particularly critical. He states that the majority of

judges distrust the experts. That they have been described as intellectual prostitutes ready to sell to either side. Further, that the way is left open for the charlatan to testify under the present system. That the trial is prolonged because of the length of the testimony. That juries are confused when one expert attempts to controvert the testimony of another. This latter I believe is a just criticism. How any jury can decide a technical medical question when experts appear for both sides, one controverting the other, is beyond the comprehension of most people.

Frazier¹¹ in an article on expert testimony reports that the opinions of twenty-five judges in England and the United States were obtained. This survey showed that seventeen thought it of little value, and eight had a good word for it. In this paper Frazier states that judges have called them "alleged experts." Here again the system is criticized, but no method of correction is offered.

At the Cleveland Session of the House of Delegates of the American Medical Association in 1934, the President, Dean Lewis said:

"The medical profession requires the good will and respect of the people. I know of nothing that makes people more suspicious of those engaged in the practice of medicine than the expert witness. Lay people must think that medicine does not even approach an exact science, when two men of equal distinction in medicine will give diametrically opposite statements to questions that are asked at a trial.

"Members of the bar realize the futility of much expert testimony, and I would like to see the bar association approached by a committee appointed by the House of Delegates to see whether some method of procedure could be devised by which the expert witness could be eliminated. A reference board, appointed by some competent authority or commission, would probably be most satisfactory, for it could examine in camera the testimony and the documents and hand down the decision, thus avoiding the amazement concerning the conflicting statements of equally capable men."

The President's remarks went to the Reference Committee on Reports of Officers which recommended:

"Relative to the method of procedure regarding expert medical testimony, it is suggested that each state medical society establish cooperation with its state bar association in an effort to correct this abuse."

One cannot help but notice in the above reviews and criticisms that very few concrete methods of correction are offered. All the criticisms seem to be about the same.

Up to now, I have reviewed the articles that I have been able to find on this subject and, where I believed it justifiable, I have defended the doctors.

And now, our own criticism of the doctors. I confess that I believe there are doctors in this State who must submit to all of the above indictments. I believe, however, they are in the minority. I feel that some men have stretched their testimony to favor the side for which they were appearing. I believe that it could be proven that their testimony was moulded to suit the particular case. I believe that the nature and extent of the injuries or illnesses have been magnified to suit the case at trial. I feel that unfair and unwarranted testimony has been given. I feel that the duration of the illness or injury has been unnecessarily prolonged. On the other hand, I also feel that doctors have appeared for the insurers or for large corporations and have minimized the injuries or illness of the plaintiff. However, I again say without fear of contradiction that the doctors guilty of these charges are in the minority.

Many attempts have been made to solve this most distressing situation, and most of them have proven fruitless.

I have circularized the attorney generals in every state in the United States and find that there are only five states in the United States with specific statutes covering the question of expert testimony.

Rhode Island has adopted a plan of disinterested experts selected by the court upon application of one or the other side. The fee to be paid by the side requesting the experts. The criticism again of course is the stretching of testimony for the side requesting it, and the fact that the fee is to be paid by the side requesting the testimony.

In Michigan each side is allowed three experts excepting in homicide cases where as many as are desired are permitted. Again the criticism of stretching the testimony for the side paying the fee. It could be commended, however, for shortening the trial.

In Washington the court may appoint the experts. Nothing is said about numbers or fees. The same method is employed in California where the judge selects the experts, but no mention is made as to numbers or the payment of fees.

In Louisiana the court may appoint experts for its own benefits or upon the request of either side. Of these laws I think a very fair criticism, and one that I think has been used before, is that a man might be a very great jurist and still be a very poor judge of the ability or knowledge of doctors.

All of the remaining states cover the question of expert testimony in a general way as we do here in

Connecticut. In other words, forty-three states have no special statutes covering the question, and five have made half-hearted or partial steps to correct it. Several states have attempted at one time or another to solve this problem, but always have been thwarted by one group or another.

With your permission, I will digress from the main subject for just a moment to discuss two allied subjects.

Lately the doctors have been severely rebuked for appearing in the minor court in cases of people charged with operating motor vehicles while under the influence of liquor. Officials have publicly criticized doctors for their appearance. I have very definite and candid ideas about this subject. If the doctor makes his diagnosis only after making the accused walk, and talk, and considering only his general appearance and actions, then I say that his opinion is not worth any more than that of a well seasoned police officer with experience in such conditions. If on the other hand the doctor is anxious to clear up such a situation and he believes that the accused is not drunk, let him hospitalize this person and determine the amount of alcohol in his spinal fluid and blood, and if these determinations are within normal range, let him go with him before any court anywhere and so testify. It is his duty to do so. If positive so report it to the court. Don't let it again be said of doctors that they are prostituting themselves in these unworthy cases.

I have made only a superficial investigation of the compensation courts in Connecticut. I believe, however, that the commissioners have done and are doing excellent work. Their work is hard, and their trusts difficult of fulfillment. I believe their work could be made easier by the appointment, by the proper authorities, of consulting boards of physicians who could aid them in determining medical values in relation to injuries and illnesses.

Returning again to expert testimony and assuming that we are correct that an undesirable situation exists here in Connecticut, what do we propose to do about it? If this is a challenge to medicine in Connecticut, I know that the State Society willingly and gladly accepts it. It must. A member of the Council has told me that an executive of a great corporation has said that if this situation was not cleared up by our medical societies, it would be cleared up for us.

Under the existing laws, any doctor may appear as an expert upon medical or surgical questions.

This, of course, is a very bad situation. I am frank to confess that I think most medical men in this State are not equipped to appear as experts. I feel, as I have said before, that it requires very special training and is as much a specialty as any of our well known or refined specialties in medicine.

A very famous medical expert here in Connecticut in discussing this situation with me has offered a very good and able suggestion. He has appeared as a medical expert, I think, oftener than any doctor with whom I am acquainted. He has suggested that an expert should not give any testimony in court that he would not give in a scientific paper before this or any other medical society. This, I believe, is the crux of the whole situation. Would these experts appear and make the bald and bold statements in a scientific paper before this Society that they make before juries? I think not. He further suggested that the fee should be a standard one and thereby eliminate the cutting question so frequently asked, "How much do you expect to be paid for your testimony?" When this question is asked the inference is obvious that the expert is appearing wholly for the fee, whether or not his side of the case has merit.

With all due deference to the honest, ability and judgment of our courts, I do not believe that judges are trained or equipped to separate or accept expert testimony or to select experts. I do not believe that this is an unfair criticism of our judges.

I believe that any solution of this problem must come from within. That is, it must come from the doctors themselves. It must be guarded and guided by the doctors themselves. In no other way can this problem be solved. If that premise is correct then the logical destination of this problem is here in our own State Medical Society.

Any correction of this situation must, in my opinion, be accomplished in conformity with section 21 of article first of the constitution of Connecticut which provides: "that the right of trial by jury shall remain inviolate." To attempt to amend this provision would be cumbersome and expensive and in all probability impossible of attainment. Therefore, I believe an optional form of legislation should be provided and I recommend to the Council of this Society, or to the committee appointed by the Council to investigate this matter, that suitable legislation be initiated, sponsored and endorsed, covering the question of expert medical testimony. This legislation to be based wholly and entirely on

the fact that this Society shall submit to the governor the names of a group of doctors covering all of the specialties in medicine. From this list of names submitted to the governor, he shall appoint a desired number who shall be known as commissioners or referees of the superior court. From the approved list of referees the judge to sit in a particular case shall select one to take medical testimony. For example, if it is predominantly an orthopedic case, an orthopedist from the group shall be selected to act as commissioner. Both sides may appear before the referee and through counsel introduce their medical evidence. Witnesses (expert) shall be subject to cross-examination.

Here you will see that the attorneys still have the right to cross-examine, and if the attorneys are honest in their desire to clear up this situation, they will not have sacrificed anything. Their belief in, and respect for cross-examination will not be denied them.

Having taken the expert testimony for both sides, and having weighed this testimony carefully the referee or commissioner submits his report to the court, to be read as evidence to the jury. The right of appeal from the commissioner's decision shall not be denied.

This proposed legislation must of course be optional and give to counsel for either party the privilege to resort to the above mentioned plan or to follow the present method which has brought expert medical testimony to a very low level and which has tended to bring dishonor to our profession. I think all will have to admit that under the proposed method juries would find themselves in very much better position to determine values than they are at present with one group of experts testifying to one thing only to be controverted by another group.

All of us I am sure, believe in the honesty, integrity, ability and judgment of any number of our members to serve adequately as commissioners or referees. There are a great many of our members whom, were they sitting as commissioners, one

would hesitate to attempt to bluff or to whom one would hesitate to make the preposterous statements which, at present, are not infrequently made to juries. There are many of our members, so revered by all, that one simply would not attempt, before them, a distortion of the truth nor would one attempt to magnify or minimize an existing condition.

Gentlemen I think here, and only here, is the solution of this problem. The solution is not based on fear of violation of any law by the medical expert, but is based on reverence of the acknowledged ability of the commissioners to be appointed.

To accomplish this I am sure there will be required meetings with other interested groups, to the end that this situation will be corrected.

Medicine in Connecticut is anxious and willing and clamoring to get this situation cleared up and it asks the state bar, large insurance companies, self-insurers, great corporations and labor for their cooperation.

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THE MANAGEMENT OF NEUROLOGICAL SYPHILIS IN A GENERAL HOSPITAL BY MALARIA INOCULATION

THOMAS P. MURDOCK, M.D., and DAVID J. COHEN, M.D., *Meriden*

FIFTEEN patients with the various types of central nervous system syphilis have received fever treatment with malaria inoculation at the Meriden Hospital. Four were private patients, the remainder were admitted to the ward medical service. The incubative period after artificial inoculation with quartan malaria intramuscularly is about thirty days. When used intravenously the incubative period is from four to twelve days. The incubative period with intravenous malaria of a tertian strain is about three to eight days. Not uncommonly with either type or either method it is necessary to stimulate the "malarial take" with shock therapy such as typhoid vaccine intravenously and when this fails, to attempt again, inoculation with malaria. Hospitals are overcrowded. Beds are needed for acute emergencies. It is expensive for the patient to spend this time in the hospital and quite unnecessary. Therefore, the following procedure was used. The patients were inoculated at their own physician's offices or at the outpatient syphilis clinic. The malarial blood was obtained from the Connecticut State Hospital at Middletown. The blood was injected on the day that it was collected. All of the patients were then permitted to go home and about their usual routine and to report to their physicians or the hospital with the onset of chill or fever. In this way many unnecessary hospital days were saved both for the patient and hospital.

Prior to admission to the hospital all patients had been worked up with complete physical, neurological, mental, and laboratory examinations. The latter consisted of blood and spinal fluid Wassermanns, cell count, globulin, and colloidal gold curves. During the febrile course, blood nonprotein nitrogens were estimated once or twice a week. Complete blood counts were done twice a week. Blood smears were examined frequently for malarial parasites. These were positive in all cases.

AGE

The fifteen patients ranged from 13 to 63 years of age at the time of the inoculation. The average age was $42 \pm$ years.

SEX DISTRIBUTION

There were ten males and five females.

DURATION OF SYPHILIS

Before inoculation this varied from a few months to thirty-five years; the average length of time before treatment was approximately fifteen years.

PREVIOUS TREATMENT

All but three of the patients had received some kind of antiluetic treatment before the institution of fever therapy. Of these three, one had tabes dorsalis, one had congenital lues and juvenile paresis, and one had the mixed type, paresis, and meningo-vascular syphilis. The others had received varying amounts of neoarsphenamine, mercury, bismuth, and potassium iodide. One patient had received tryparsamide.

ONSET OF C.N.S. SYPHILIS

The onset of the central nervous system syphilis according to the history varied from a "few weeks" to eight years before fever therapy was instituted. The complaints of the patients were variable: ptosis of an eyelid, pains in the legs, loss of deep sensation in the legs and feet, gastric crises, hemiplegia, diplopia, staggering gait, "nervousness," "limp in the leg," difficulty in passing urine.

TYPES OF CENTRAL NERVOUS SYSTEM SYPHILIS

Tabo-paresis ...	5	Meningo-vascular	
Tabes	5	+ paresis	1
Paresis	2	Juvenile paresis	1
		Asymptomatic	1

At the onset the diagnosis of syphilitic involve-

ment was established in 12 instances by clinical and laboratory data, in two instances by laboratory examination, and in one case by clinical means (tabes dorsalis).

PHYSICAL EXAMINATION

Pupillary changes were found to be the most prominent and consistent abnormal finding. These varied from slight inequalities to the typical Argyll-Robinson type. Of the fifteen patients, thirteen showed some degree of pupillary change. One patient showed optic atrophy. The two patients who failed to show pupillary changes were tabetics.

Of the ten cases of tabes and tabo-paresis there were eight with loss of knee jerks or ankle jerks or both. Four of the five with tabo-paresis had tremors of the tongue or hands or both.

Hemiplegia of sudden onset was a presenting sign in the mixed type. In this case the colloidal gold curve was of the paretic type.

Seven of the fifteen cases presented mental changes. These varied from "nervousness" to marked deterioration. These changes were present in the paretics, tabo-paretics, and in the case of juvenile paresis. There were the usual disturbances of memory, confusion of ideas, euphoria, impairment of judgment, emotional changes, lack of insight, and impairment of calculation. One of the tabetics was "nervous" but complained of no other symptoms.

BLOOD SEROLOGY

At the time of inoculation with the malaria the blood serology was positive in nine of the fifteen cases or 60 per cent.

- 3 positive in 5 tabo-paretics
- 3 positive in 5 tabetics
- 2 positive in 2 paretics
- 1 positive in 1 juvenile paretic
- negative in 1 mixed type
- negative in 1 asymptomatic

SPINAL FLUID EXAMINATIONS

In all cases but one there was evidence of spinal fluid changes either in the Wassermann reaction, cell count, globulin or colloidal gold curve. The spinal fluids were examined at least once prior to the malaria treatment, twice in two cases, and three times in three cases.

The five cases of tabo-paresis presented the following data: 1. five positive Wassermans; 2. absence of cells in 3 cases, 123 lymphocytes in one case, and no record in one; 3. two positive globulin

reactions, two negative reactions and no record in one; 4. one tabetic colloidal gold curve.

The five cases of tabes presented the following data: 1. four showed positive Wassermans; 2. absence of cells in three cases, 120 lymphocytes in one and 22 lymphocytes in another; 3. the globulin was positive in three cases and negative in two; 4. one positive colloidal gold curve.

The two paretics had positive spinal fluid Wassermans. One had a tabetic colloidal gold curve while the other had a typical paretic curve. In one there were twelve lymphocytes and a 4+ globulin. No record of cells or globulin could be found in the second.

The "mixed type" case showed a positive Wassermann, absence of cells, 1+ globulin and paretic colloidal gold curve. The juvenile paretic presented a positive Wassermann, absence of cells, 1+ positive globulin, and negative colloidal gold curve.

The asymptomatic case had but a positive Wassermann in all quantitative dilutions (0.2, 0.1, 0.05).

The tabo-paretics showed the following data in the spinal fluids after treatment:

- (1) Reversal of the positive Wassermann in 3 of the 4 cases.
- (2) Reversal of cells in one, from 123 to 0.
- (3) Reversal of tabetic colloidal gold curve to zero reaction.
- (4) No record in one case.
- (5) Reversal of the globulin reaction in one case.

The spinal fluids demonstrated the following facts among the five tabetics:

- (1) Reversal of Wassermann in one.
- (2) Reversal of cells in one, from 120 to 0.
- (3) Reversal of tabetic colloidal gold curve to zero.
- (4) No change in one case.
- (5) No record in two cases.

The management of the paretics was the most unsatisfactory. One patient refused to return to the hospital for spinal puncture. In the second case fever treatment had to be interrupted because of delirium, incontinence, and extreme weakness.

The "mixed type" case has maintained a positive Wassermann in the spinal fluid, but the globulin reaction has changed from one plus to zero, and the paretic gold curve has reversed to normal (0012210000).

The asymptomatic patient showed reversal of spinal fluid Wassermann.

The juvenile paretic demonstrated reversal of the Wassermann and globulin in the spinal fluid.

In the first two cases, the tertian variety of malarial parasite had been used and given intravenously; the incubation period was on the sixth day in the first case, the third day in the second case. All the other patients had been inoculated with the quartan type, three of them intravenously and the last ten intramuscularly. The incubation period in the last group varied from 25 to 44 days.

There were several factors in the patients' condition that were closely watched during the period of chills and fever.

(1) Development of secondary (hypochromic) anemia.

(2) Increase in nonprotein nitrogen.

(3) Enlargement of the spleen.

None of the patients had erythrocyte counts that fell below 3.0 million per cubic mm. Five of the patients developed palpable spleens, but none of them became tremendously enlarged. Four patients demonstrated increase of the NPN to levels above normal, namely 48, 50, 100, 55. At no time were there any symptoms suggesting a plasmodial meningitis. Two patients developed phlebitis during the febrile course. No jaundice appeared during the fever bouts, nor did erythrocytes appear in urine. No quinine or atabrine resistant cases were found. Plasmodia disappeared after the institution of quinine or atabrine and remained so. No granulocytopenia occurred during quinine therapy.

Kopp and Solomon¹ have reported edema occurring during malarial fever. They have associated this with low serum albumin. They felt that the edema occurring during the course of therapeutic malaria in patients free from renal damage or cardiac failure is probably aggravated by an increase in sodium chloride intake. Judd,² however, feels that these patients should be given sodium chloride rather liberally because of the loss of sodium chloride associated with elevation of temperature and sweating. Edema did not develop in any of our patients. They were given house diets, either regular or soft, without increase or restriction of salt.

In the early days of malaria therapy the amount of treatment was measured by the number of chills. This was soon recognized to be inaccurate because of the variation in severity of the chills and the

height and duration of fever. It is better to figure the intensity of therapy by the number of hours of fever above a certain mark which we selected as 103° F. The average number of hours experienced was 71 +.

The average number of days in the hospital was 41. This is of economic importance in planning the course of fever therapy for neurological syphilis.

Of the 15 patients, two have died of causes independent of the central nervous syphilis: a paretic of cerebral hemorrhage, and a tabo-paretic of coronary closure. Ten are known to be alive, and the whereabouts of three are unknown, namely, one paretic, one tabetic, and one asymptomatic.

There are four tabo-paretics living. Of these one has complained of occasional lightning leg pains, ever since the fever therapy seven years ago. The condition of two is unchanged; whereas the fourth shows improvement in dysarthria, tremor, and lightning pains.

The four tabetics are doing well. One feels subjectively better; he sleeps better and the lightning pains in his legs have disappeared. He no longer complains of nervousness. His pupils, previously fixed, now react to light. This patient now has a B.P. of 190/85 and a systolic aortic murmur, thus raising the possibility of aortic insufficiency. Another is likewise feeling better. One year ago he had an attack of chest pain probably of a radicular type which lasted for a short time and has not recurred. Two others are symptom free.

The mixed type is slightly better. His pupils react better to light than five years ago. The tremor of hands has disappeared, but the tremor of tongue is still present. The Wassermann of the spinal fluid is positive, but the colloidal gold has remained negative.

The juvenile paretic is unchanged clinically. However, his spinal fluid has become serologically negative only in the past few months, two years after the therapeutic malaria. This reversal is unusual in congenital syphilis with paresis, but is consistent with the delay of serological change that occurs among other kinds of neurosyphilis.^{3,4}

SUMMARY

The blood Wassermann was positive in nine of the cases.

The spinal fluid Wassermann was positive in fourteen of the cases. There was an increase in the cell count in four cases. The globulin was positive in

eight cases. The colloidal gold curve was positive in five cases.

After treatment the Wassermann was reversed in five cases and in another a reversal occurred two years later. The cell count returned to normal in two cases. The globulin was reversed or reduced in intensity in two cases. The colloidal gold curve was reversed in three cases.

Six of the fifteen cases have shown symptomatic improvement.

The results obtained in this small series leave much to be desired in the treatment of neurological syphilis. It is difficult for some clinicians to accept the efficacy of the arsphenamines in the treatment of syphilis. Until a more effective method is provided for the management of syphilis in general, it

would seem wise to continue with the fever management of neurological syphilis.

CONCLUSIONS

1. Fifteen patients with neurological syphilis have been given fever therapy by malaria inoculation. The results are outlined.

2. A method is suggested which is safe and at the same time less expensive for the hospital and the patient.

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PREPAYMENT MEDICAL CARE

THOMAS P. MURDOCK, M.D., *Meriden*

ON NOVEMBER 19, 1945 the President of the United States presented a message to the Congress transmitting his request for legislation for adoption of a National Health Program.

On the same day Senator Wagner brought into the Senate the bill now known as Senate Bill 1606 or the Wagner-Murray-Dingell Bill and Congressman Dingell presented it in the House of Representatives. These bills were obviously presented to implement the President's proposals.

It is my impression, and I think I am correct, that this is the third bill presented to the Congress by these men. The present bill differs from the others in that no mention is made of finances. Therefore, this last Senate bill was not sent to the Senate Committee on Finance but was sent to the Senate Committee on Education and Labor of which Senator Murray is a member and the House bill was sent to the Committee on Interstate and Foreign commerce instead of the Ways and Means Committee. The

proponents of the bill have been criticized for this. Senator Wagner discussed his reasons for proceeding in this way on the opening day of the hearing before the committee.

The President's message exhaustively outlines what he calls "The right of the people to adequate medical care and the opportunity to enjoy good health."

The message covers five points. The first has to do with the number and distribution of doctors. He believes that the unequal distribution of physicians would be corrected if the facilities for practicing were improved. If this is so then the answer lies in the acceptance of the Hill-Burton bill. This bill provides grants in aid to the various states for increasing hospital facilities where the need can be shown. The American Medical Association and the majority of the doctors in the United States have endorsed this bill. I am sure, however, that it is not the whole answer to the question of unequal distribution of physicians. An additional answer probably lies in

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the production of greater numbers of physicians while at the same time maintaining high standards of training and ethics.

The second phase of the message has to do with the development of public health services and maternal and child care. I am sure that all physicians, as well as all the people, are in agreement with any method developed to improve maternal and child care, even including governmental bureaucratic methods, provided the need can be shown.

The third phase has to do with medical research and professional education. This, too, is an accepted premise. However, one fears greatly the danger of the injection of politics into research and professional education. Our own Dr. Creighton Barker has said that due to taxes and other conditions "the wells of philanthropy have probably run dry" and medical departments at universities will find it more difficult to obtain private endowments. I think it can be accepted that government subsidy of universities is proper providing politics can be eliminated. This will be difficult. The Bush committee has recommended this for research provided it is governed by a group of scientists as consultants and not by political bodies.

The fourth phase has to do with loss of earnings during illness. All doctors, I am sure, are in favor of insurance covering loss of earnings during illness but I am also sure that most physicians have had experience with the problem it presents. Patients not covered by insurance all too frequently desire to return to work too quickly. The converse is also true—all too frequently patients covered by compensation or other forms of insurance are inclined to prolong their convalescence. It is difficult to establish a balance here and it would have to be carefully guarded and guided.

The fifth phase has to do with compulsory health insurance on a national basis.

This medicine objects too seriously for many reasons, four of which are extremely important. The compulsory phase is dangerous both to the people and the physicians. The frugality and intelligence of a whole people are questioned. The right to voluntary procedure is denied a people. In substance they are told, you are incapable or unwilling to make this decision for yourselves, therefore, we will do it for you. This is a new philosophy in a democracy. It is a mandate which is compulsory and they must conform to it. The right of freedom is denied them.

The physicians are told that this is the way medicine is to be practiced and they must conform.

Secondly, the danger of dictatorship is great. The chief of the Public Health Service is to be in charge. It is true that there is to be an advisory board of twelve men. However, the chief of the Public Health Service selects the advisors.

Thirdly, the control will in all probability fall into the hands of politicians. Human beings being what they are it is most natural for this to take place. In my opinion political medicine will result.

Fourthly, any plan or method of prepayment should be on a local, county or state basis. On these levels conditions are more clearly understood. A rule or law made or interpreted in Washington has a different application in Arkansas than it has in Connecticut. The fitness of things in Connecticut are known far better by the people of this State than by the bureaucrats in the national capitol.

In answer to the President's proposal and the Wagner-Murray-Dingell bill the American Medical Association and the various state and county societies have come forward with concrete provisions retaining the basic principles of free enterprise.

American medicine through the Board of Trustees of the American Medical Association has laid down certain required principles and the Council on Medical Service of the American Medical Association has set up certain standards for qualification. Some of these are that the prepayment plan must have the approval of the state or county medical societies in the area in which it operates. The medical profession must assume responsibility for the medical services including the benefits. The plans must provide free choice of qualified doctors and must maintain the personal, confidential relationship between physician and patient. Plans must be organized to provide the greatest possible benefits in medical care to the subscribers. These plans may be on a service basis or an indemnity basis. Approval of state insurance authorities must be obtained. Systems of accounting must be carefully followed.

A voluntary federation known as the Associated Medical Care Plans has been established on a national basis. This organization was incorporated in Illinois on March 30, 1946. It is an independent association and will include as members only those plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The associated medical care plans will undertake to

establish cooperation and reciprocity between the various plans to permit transference of subscribers from one plan to another. This will provide for coverage of large industrial organizations with plants located in several states. It will further provide welfare groups and the Veterans Bureau with coverage for their subscribers. An analytical service will be provided by the Associated Medical Care Plans so that the best in each of the plans will be available for new plans to be started. Local autonomy is guaranteed. This federation will act in a cooperative and advisory manner only.

The Board of Trustees has announced a division of prepayment medical plans with a director and a staff who will administer the activities related to the promotion and development of various plans. Mr. Jay Ketchum, the administrator of the Michigan plan has been selected for this position. He is probably the outstanding authority on prepayment medical and hospital plans in America.

The Board of Trustees has also presented a complete health program. This is to replace the original health plan as outlined in 1945 and will be brought up to date as indicated and required by changing conditions and times. This revision is as follows:

- (1) A minimum standard of nutrition, housing, clothing and recreation is urged.
- (2) Preventive health services through competent health departments subject to community needs.
- (3) Adequate prenatal care for prospective mothers.
- (4) Care of all infants as to nutrition and immunization against preventable diseases.
- (5) Health and diagnostic centers and hospitals necessary to community needs.
- (6) The establishment of voluntary nonprofit prepayment plans for the coverage of hospitalization and medical services. The principles of such contracts should be acceptable to the Council on Medical Services of the American Medical Association.
- (7) Complete care of veterans including medical care and hospitalization with the payment by the Veterans Administration through a plan mutually agreeable to the Veterans Administration, State Medical Associations, and prepayment plans.
- (8) Recommendations for the advancement of medical science through a national science foundation.
- (9) Continuation of voluntary philanthropic health agencies such as the National Tuberculosis

Association, the National Foundation for Infantile Paralysis, Commonwealth Fund, Rockefeller Foundation.

- (10) Wide spread education in the field of health.

Several of these recommendations should be operated on a local or county or state basis with government aid only where need can be shown.

The number of prepayment nonprofit medical plans continues to mount. The figures change almost daily. The last official report I have is as of April 16, 1946. This shows 47 plans in operation in the United States covering 2,800,000 people. Plans are in operation in 28 states and eight are in process.

The number of prepayment nonprofit hospital plans in operation now is said to be 86 in 43 states and covering 21,000,000 people. The number of people covered by old line companies with health and accident policies is 40,000,000.

Residents of 20 states may now enjoy protection against both medical and hospital expense through medical or surgical service plans sponsored by local, county or state medical societies operated in connection with Blue Cross.

For several years the Connecticut State Medical Society studied the various plans for prepayment medical care. It was an intensive and at the same time an inexpensive study. Many of the mistakes of other state and county societies were avoided and the experiences of these societies were carefully studied. During this study conferences were held with the managers of various plans throughout the United States. The study also included conferences with capital, labor, social service groups and doctors within the State. Fee tables covering the Veterans Bureau and various State Compensation Commissions were studied. Medical men representing the general practitioner and the various specialties were called in for general advice and for advice covering the fee schedules. In this way only a very small amount of money was spent as compared with such states as Michigan and California.

Finally a plan was decided upon which would cover surgery, obstetrics and orthopedics in the hospital and some surgical conditions which could be treated in the doctor's office.

The next move was to arrive at a decision as to the advisability of placing this with an old line carrier or on a nonprofit sharing basis. During this time the pendulum swung back and forth several times. It was finally decided to place this with an old

line carrier. The Connecticut State Medical Society has had a very happy experience with an old line carrier covering group disability insurance for its members. This company and its representatives became intensely interested in this subject. Dr. J. R. Miller, then Chairman of the Council of the Connecticut State Medical Society and the Secretary, Dr. Creighton Barker, held several conferences with its representatives. Progress was made and I may say almost to the point of closing. An unfortunate and unforeseen situation developed in which the representative of this company, in whom the officers of the State Medical Society had great confidence, was forced because of physical disability, to discontinue his work. The committee then pursued the matter on a nonprofit sharing basis and after several conferences with the officers of the Connecticut Hospital Service, Inc., it was decided that the actual work of promotion and sale would be done by this group.

A Board of Directors was selected including representatives from this Society and prominent lay people. The majority of the Board of Directors are members of the Connecticut State Medical Society. This organization was completed and the directors have held several meetings.

The complete table of organization was then sent to the State Insurance Commissioner for approval. This included the law permitting the action, the enabling act, the naming of the amounts of capital to be furnished by the Connecticut State Medical Society and the Connecticut Hospital Service, Inc., the fee schedules and plan of operation. We are awaiting his approval.

Unfortunately, about this time the Connecticut Hospital Service, Inc. got into financial difficulties and at the instance of the state insurance commissioner it was necessary for the Connecticut Hospital Service, Inc. to get its house in order before it would be permitted to engage in the sale of the new plan. As soon as permission is granted the plan will be placed in operation. If this permission is not

forthcoming soon other arrangements for its operation will be considered. The immediate details in so far as the Connecticut State Medical Society is concerned are completed. We are ready to go as soon as approval is obtained. In general, I am sure that this plan will meet with your approval. I think I should divert at this time to say that in my opinion some form of prepayment plan is on the books. We must do it ourselves. It is obvious I think that this plan or any plan cannot succeed unless it has the whole hearted support of the doctors. We ask your enthusiastic endorsement. This plan conforms and will conform to the requirements of the Board of Trustees of the American Medical Association, and to the standards for qualification set up by the Council on Medical Service of the American Medical Association.

The proponents of the federal compulsory plan have lost sight of the fact that the great majority of the physicians in America are opposed to the compulsory phase of the national act. They are selling the market short. It is not at all certain that they will be able to give the people what they propose to tax them for either by general or specific taxes. As was said before any plan that has not the generous cooperation of the physicians will fail.

It is my considered opinion that some national organizations who are sponsoring the Wagner-Murray-Dingell bill, sincerely, are being made the innocent tools of international organizations whose philosophy is foreign to America and Americans.

I believe that not only American medicine but all of America finds itself at the crossroads. Which way will it turn? Will it turn to the left and accept the philosophy of socialism or communism or will it turn to the right and continue progressively with free enterprise and thought? I don't know. If it is the latter, I am sure that American medicine will continue to do its utmost to provide for all the people "The right to adequate medical care and the opportunity to enjoy good health."

DISEASES IN MIDDLE LIFE AND BEYOND

THOMAS P. MURDOCK, M.D., *Meriden*

LIFE expectancy in the last forty years has increased from 49 years to 65 years. This is reassuring and it augurs well for a continued increase. There is another side to the picture, however, which we must face if this prophesy is correct. Will the brain continue to function as well as needed? Will the mind be as alert and keen as it should be? Will brain deterioration precede by any great length of time the physical break-up which is sure to come? All men must die once. Would it not be better to break up physically before mental deterioration presents itself? I will let each of you answer this for yourself.

I am sure that the list of degenerative diseases in middle life and beyond, which we would attempt to prevent, postpone, or detect early would depend wholly on who draws the list. The surgeon probably would present a list of surgical diseases; the psychiatrist, one of psychiatric diseases; the orthopedist, orthopedic problems. I would suggest (1) vascular diseases, including heart and kidney diseases, (2) diabetes mellitus, (3) carcinoma, and (4) injuries.

One wonders at times whether some of these conditions can be prevented. With our present knowledge it seems very unlikely that diabetes mellitus and vascular disease can be. Heredity and tendencies play such a very important part in the human make-up that despite the greatest care some of these degenerative diseases will develop.

It is now generally accepted that diabetes mellitus is governed by the Mendelian Law. If two diabetics marry, all of their children will develop diabetes, if they live long enough. If one diabetic marries a non-diabetic with a diabetic strain one half of their children will develop diabetes. If a diabetic marries a non-diabetic without a diabetic strain the procedure will be interrupted.

A similar tendency if not an exact situation exists

in the case of vascular disease. It is not uncommon now to see several members of a family with vascular disease. It seems to occur more frequently than if it were just a natural variation.

But even if these guesses as to prevention are correct, I am sure that with proper care a good job of postponement can be done with these two groups. That the onset can be postponed and the progress limited are facts accepted by most clinicians. There is also, of course, the problem of early detection.

The potential diabetic must keep his weight at standard or perhaps 10 per cent below standard. He must carefully balance his diet so that undue stress will not be placed on his pancreas. He should submit to an annual physical examination including, of course, urine and blood sugar studies.

The patient who is a potential vascular disease fellow should not engage in physical or mental overstrain. He should be his age as to physical exercise and avoid physical overstrain. Also he should not overtax his brain. He must protect his legs and feet particularly against physical strain. And, of course, his heart muscle and coronary arteries should not be asked to carry undue loads. This man, too, should limit his food intake and hold his weight to standard or 10 per cent below.

Now we come to the question of management of the people in this group if they develop any of these diseases. Good common sense is required. Don't rule of thumb them; treat each individually. Treat the patient specifically and not his disease. We must not have too many don'ts in this management. If too many restrictions are placed on the diabetic he will violate all of them. If too many limitations are placed on the man with vascular disease, he, too, will violate all of them.

Specifically in the case of the diabetic try to plan

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for a long future. Attempt to get for him his full expectancy of life. Do not be too critical of minor violations of diet. This probably sounds like a heresy, but I have yet to see a diabetic coma that I could attribute to overeating. It is rather due to discontinuing insulin, failure to eat, or to acute infections. Pay close attention to the management of complications, particularly acidosis and coma. Quickly take care of both acute infections and his diabetes. Give him sincere and logical advice about his feet.

The patient with vascular disease must limit his physical and mental exertions so that stress will not be placed on his blood vessels. We must remember that in this disease the organs most frequently involved are the brain, heart, kidneys, and feet. These people should be advised accordingly. Many of them have ideas of their own regarding the management of their disease. They feel that they must engage in vigorous physical exercise so that their musculatures will be restrengthened, and they can reduce their weight. Such ideas are unsound physiologically and pathologically. A limited amount of exercise probably will be helpful, but it is probably impossible for them to reduce their weight by that means. Weight reduction should be accomplished by an intelligent reduction in caloric intake. Some of them will make a sincere try although others seem actually unwilling to make the sacrifice of reduction of food intake.

The cancer patient is entitled to early diagnosis. To achieve it health education for all of the people is the first requisite. They must be taught the importance of pain, lumps, and bleeding. It is the duty of health workers to carry on this teaching. There seem to be two groups of the public at the present time whose reactions to the question of tumors are diametrically opposite. One group hungers for this knowledge and the other group avoids it. Avoidance, no doubt, is based on fear. Those who reject knowledge have come into notice since so much publicity has been given to the question of tumors. The American Cancer Society and government subsidies for the study and care of cancer have brought this problem to the front where it rightly belongs. Tumor clinics are now established in all good hospitals. It cannot be said that anyone in need of diagnosis or treatment of tumor is denied it on the basis of the expense involved. Early diagnosis on the basis of the complaints of lumps, bleeding, and pain in persons of this age is important. The caution

to be given them is that they should be sure to visit a tumor clinic or their physicians with the appearance of the first symptom.

Next we consider a condition seldom mentioned in the discussion of the aged and that is the whole matter of injuries. Older people are much more likely to fractures than are other age groups. Vision is poor, gait shuffling, dizziness is common, and they fall and injure themselves. The good orthopedist is the logical one to undertake their care in this case. He thinks of the patient as a whole and does not treat the fracture specifically. He gets his patient out of bed early to prevent complications. It is good practice on the one hand to warn nurses to be careful with people in this age group and on the other hand to warn the family that accidents can happen in spite of hell or high water. I plead for more caution in the prevention of accidents in the aged. These are frequently serious. In some instances it means total invalidism, with the best that one can expect a long period of convalescence. I have a particular fear of bathrooms and bath tubs for older people. Injuries seem to happen here more frequently than in other parts of the house. Obviously this is a nursing problem or at least a family or attendant problem.

Dr. E. M. Bluestone* divides the patients with long-term illness who occupy beds in the hospital for chronic diseases of which he is director, into three groups:

1. Patients who should have been kept in the "acute" general hospital and not sent to a hospital for chronic diseases. He felt that the latter occurred because the medical staff in the general hospital lost interest in them, because they lacked financial means, and because the beds were needed for more acutely sick patients. Group 1 are the overwhelming majority.
2. Patients who can be well cared for in their own homes, but who for social reasons are sent to hospitals for the care of chronic diseases. They are in the minority.
3. Patients who suffer from a residual handicap due to permanent scarring. These people need care in an institutional type of home if they cannot be kept in their own. These, too, are in the minority.

I am in hearty agreement with this analysis. All

*Bluestone, E. M., M.D.: Long term illness in modern society. *Journal of the American Medical Association*, April 12, 1947, vol. 133, p. 1051-53.

too frequently we violate our trust by failing to care for patients with long-term illness in their homes and in general hospitals.

In general I am heartily in favor of having young people in and out of the healing arts. They are doing a fine job. However, if any criticism could be made of them it is that they are unwilling to care for the aged. Those out of the healing arts seem anxious to shuttle the aged from their homes into hospitals chiefly for domiciliary and custodial care. Those within seem anxious to shuttle them again from hospitals into homes for chronic diseases. If we do not change our policy in this regard we will and should be criticized. Without question some belong in hospitals for chronic diseases, many in general hospitals, and some at home. Let us all select more carefully.

The dietary management of people with chronic illness is not difficult. The diet for all in the old age group should be simple and nutritious. In the case of the diabetic most of the required calories should be obtained from carbohydrate and protein, and the fats restricted. However, our dietary outlines need to be elastic. In the case of the patient with vascular disease remember that he requires a gram of protein per kilogram of body weight to maintain himself. The question of alcohol will come up. I believe in it for these people. I think it was Osler who said, or at least it was attributed to him that "anyone who drank alcohol before forty was a fool and anyone who didn't drink it after forty was likewise a fool." Dr. Roger I. Lee, of Boston, writing on the care of the aged said, "the three indispensables in the man-

agement of these people, and in the order of their importance are whiskey, flattery, and milk."

As to medication be cautious; don't over-medicate. When indicated, of course, whether it be insulin or digitalis or perhaps vitamins, or all of them, see that they are given but don't overdo it. Again good judgment and balance are the requirements.

The subject of geriatrics has taken its rightful place in medicine. Ways and means have been provided to increase life expectancy. Therefore, it is our duty to see that old people are given adequate and kindly care. Unless forced to do so, avoid any radical procedures. If you are faced with an elective procedure, lean toward the conservative side. Remember always that you are dealing with life's most priceless possession. Treat them as you would a frail bric-a-brac. One frequently notices the love that many people have for antiques. They are fondled; they are protected; they are shown great care. Unfortunately, and I regret to have to say this, although old furniture and old china are revered little consideration is given to our human antiques.

Finally, let me say that many of the degenerative diseases that occur in middle life and beyond probably cannot be prevented. Postponement is possible. The management of people who suffer from them requires good common sense and kindness. Early detection of these conditions is the direct responsibility of all healers. The care of the injured in this group likewise requires good judgment. Let us be conscious of, and alive to our responsibilities.

THE NURSING PROBLEM, EDUCATIONAL ASPECT

THOMAS P. MURDOCK, M.D., *Meriden*

THE NURSING problem, particularly that phase having to do with the shortage of nurses, is probably the most serious matter confronting American medicine today. Hospital authorities have been complaining of their inability to adequately staff their institutions. Doctors have maintained that seriously ill patients were being denied badly needed nursing care. Nurses are insistent that they have been carrying an enormous burden due to the shortage.

That the seriousness of the situation is appreciated one can readily see by the actions taken by several national medical organizations including the American Surgical Society, the American College of Surgeons, the American College of Physicians and the American Medical Association. All of these organizations have appointed committees to study the problem.

A nursing structure study is being conducted by Dr. Esther L. Brown for the National Nursing Council on a grant from the Carnegie Foundation. Because of her background and training and experience it is expected that her study will be comprehensive and her report awaited with great interest.

All interested agree that there has been and is a shortage. There is some disagreement as to the degree and cause of the shortage and methods of correction. A recent survey by the American Hospital Association seems to indicate some relief. Replying to a questionnaire 2,300 hospitals answered and of this number 37 per cent replied that if more nurses were available they would not need to engage them. We hope that when our study is completed all of these questions will be fully and finally answered.

"Facts About Nursing 1947" shows some very unusual and interesting figures. In 1940 there were 371,066 graduates and students in training. In 1910 there were 82,327. Of the number in 1940, 97.7 per cent were females and 2.3 per cent were males. And of this number there were 7,065 female negro nurses and 127 males.

"Facts About Nursing 1946" also provides some very interesting and unusual figures. The number in active practice 317,800. The number admitted to training schools in 1940-38,000. In 1942-47,500. In 1943-53,074. In 1944-67,051. In 1945-57,000. In 1946-30,899. From these figures you will notice the large increase in numbers admitted to training schools from 1942 and including 1945. This, of course, is explained by the Cadet Nurse Corps program. Were the increases due to patriotism, glamour of the uniform, the stipend? The answer to the whole problem is probably in these figures.

The demand for nurses increases by leaps and bounds. In 1910 there was one nurse per 1116 people. In 1946 there was one nurse per 316 people. One million more patients were admitted to hospitals in the U. S. in 1946 than were admitted in 1945. Prepayment hospital and medical plans have and will have much to do with this problem. As the plans increase in number and subscribers, the demand for hospital staff nurses and private duty nurse will increase and will have to be provided.

A report recently released by the Women's Bureau of the U. S. Department of Labor is staggering. The release estimates that the number of nurses needed in 1960 will be 500,000 to 550,000. This is based on an estimated population in 1960 of 153,375,000. It is described "as a realistic appraisal of possible attainment rather than an estimate of what ideally is desirable." To obtain what they describe as "ideally desirable" would require twice this number. As the result of the cadet corps training 44,700 nurses were graduated in 1947. This was the largest class graduated. This standard will have to be maintained during the period 1951-1960 if the estimated needed result is attained. These figures may be fantastic. I hope they are.

The economic studies present some interesting conditions. It is difficult to work out an average salary paid nurses in the United States. In 1946 it was estimated that the average income of the nurse was \$170 to \$175 a month. In 1947 one estimate

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placed it at \$185 a month. Another between \$175 and \$180. In general the average week is forty-four hours. Social security is not provided. Only a few hospitals have provided retirement plans. The American Hospital Association has worked out a retirement plan. Only a small percentage of nurses have taken advantage of this and only a few hospitals carry it.

One could ask why the shortage of nurses? There would be many answers and included in these would be (1) the general woman power shortage due to the competition of business in the labor market; (2) relatively small pay and long hours of work; (3) poor living conditions and lack of provision for recreation in training schools; (4) lack of retirement funds; (5) not being covered by social security; (6) the nurses describe a hard medical and nursing hierarchy.

I think we can all accept the first and second premises with the women power shortage and small pay. These young ladies actually take graduate work that in time, at least, is comparable to college training and are then required to work for a salary that could easily be obtained in other lines of work and without the added three years of training.

In many hospitals the living conditions of nurses are poor. Dormitories are crowded. Little or no provision is made for recreation. This is due to lack of funds or short sightedness on the part of boards of directors.

Retirement funds and social security must be provided. This is not said from a moral viewpoint. On the contrary, these must be provided if hospitals and other health agencies are to compete with industry and business in general.

The files of the committee contain a great many letters from nurses severely condemning what in general they call the hard medical and nursing hierarchy. The nurses, in these letters, state that doctors have been unfair and unjust in their criticisms. Using their own phraseology they say that doctors have "lorded it over them." They are also critical of hospital administrators and nursing educators because of their dictatorial attitudes. This should be and probably can be corrected.

What is to be done about all this? It is a big and difficult problem. It concerns us all personally and more than that it concerns American Medicine greatly. There are those who would use this situation as an indication of the need of compulsory medical and nursing care. This is not so and I deny

it vehemently. It insults one's intelligence to be told that governmental interference, and I use the phrase advisedly, would provide more or better nurses any more than it would provide more or better doctors.

I would like to say at this time that the nurses are as anxious as any group to have this problem solved. They have been most cooperative and helpful to the committee.

The committee will make its final report to the House of Delegates at the annual meeting in June. The study is nearing completion. It would be improper for me at this time to present it here even as far as we have gone. The report belongs properly to the House of Delegates. When it is in I hope it will please you.

I can tell you that a permanent conference committee has been formed. This committee is made up of representatives of the nursing profession, the American Hospital Association and the American Medical Association. The Board of Trustees has appointed a committee to represent the American Medical Association. This conference committee has already begun to function and will attempt to solve problems common to all. The committee continues its studies along the lines: of (1) immediate relief; (2) future planning for training of bedside nurses and nursing educators; (3) economic studies.

The American Medical Association intends that this problem will be solved, and more, that never again will America find itself in this position.

The President, Dr. E. L. Bortz, has stated that all of the resources of the American Medical Association are behind this study. The Board of Trustees and the Chairman, Dr. Elmer Henderson, have given the committee complete support. The editor of the *Journal*, Dr. Morris Fishbein, has greatly aided the committee from his large fund of knowledge of this subject.

The committee asks the help of all the doctors in the United States. It asks the endorsement of the National Conference on Medical Care. It is receiving great aid from editors of a great many state and county medical journals. Many of the editors have written several editorials.

This problem is one for nurses, doctors and hospital executives to solve. It is not the problem of any one group. The nurses are allies and aides to doctors. It must and will be solved with the generous cooperation of all. The committee of the American Medical Association seeks your aid.

THE MEDICAL PROFESSION'S INTEREST IN INDUSTRIAL MEDICINE AND SAFETY SERVICES

THOMAS P. MURDOCK, M.D., *Meriden*

THE picture in industrial medicine in Connecticut has changed considerably in the last thirty years. There were but few industrial plants covered by physicians thirty years ago and medical men were not disposed to approve this branch of medicine. It was classed as contract medicine. In general the caliber of men engaged in industrial medicine was not of high educational standard. Medicine felt that there was great danger that the quality of medicine would be lowered. It felt that inroads would be made on the family practitioner and that the injection of a third party would destroy the physician-patient relationship, also that competitive bidding for services would be harmful to patient, physician, and industry.

At that time industry itself did not have a high regard for the industrial physician or for industrial medicine. It felt that the industrial physician was a meddler. The old time industrialist looked upon the industrial physician as an intruder. He believed that the industrial physician did not know anything about industry, its problems, or its plants. A great change has come into being about this type of practice. Here in Connecticut some of our best physicians are engaged in this work. Some are on full time, some part time, and some are covering several small plants. They are doing a needed and useful work. Workmen are given careful physical examinations. In some plants frequent chest x-rays are taken. Absenteeism is being reduced. Contagious and infectious diseases are more readily controlled. When indicated, workmen are sent to their family physician for the care of all diseases, including the important degenerative, metabolic, and neoplastic diseases. In other words, the health of men in industry is being more carefully protected.

The Connecticut State Medical Society approves industrial medicine and recognizes its importance. The Committee on Industrial Medicine, which is

recommended by the Council of the State Society for approval by the House of Delegates, is the most active committee in the State Society.

The importance of the Division of Industrial Medicine in the State Department of Health cannot be overemphasized and Dr. Albert Gray, the director, has a national reputation. His contributions and the contributions of the department are well known. It would be impossible to tell the number of lives that have been saved by the advice and direction given by him and the Department to industry.

Men of industry and industrial medicine do not have to be told the story of pneumoconiosis and allied pulmonary lesions. The July, 1947 issue of *Occupational Medicine* was dedicated to Dr. Leroy W. Gardner, a native of Connecticut. The thousands of lives that have been saved and will be saved in the future is an everlasting monument to his work in industrial medicine. Here in Connecticut we are very proud of him.

Greater stress must be placed on the importance of teaching industrial medicine in our medical schools. President Alan Valentine of the University of Rochester, in an address in Chicago in February at the meeting of the Congress on Medical Education and Hospitals, said that there were not more than three universities in America with good industrial medical departments. This must and will be corrected.

During the past few years close cooperation has developed between Yale University School of Medicine and the Connecticut State Medical Society. This is as it should be. During this time the medical school has started a division of industrial medicine. The Connecticut State Medical Society is proud of its participation in this development. It is important that young men who are to do this work in the future should be properly trained. The industrial physician of the future in Connecticut will be in a

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highly specialized field and must obtain and be given specialized training. Dr. R. F. Buchan, who is in charge of this work at Yale, is a member of the Committee on Industrial Medicine of the Connecticut State Medical Society. Two refresher courses on industrial medicine have been given at the medical school during the past few years. This activity is important in order that the medical men in industry and those in general practice who do part time industrial work will be able to guarantee workmen the best possible medical care.

We look forward to the day here in Connecticut when our larger hospitals will have services devoted entirely to industrial medicine. And why not? It is a big and active and selective specialty. The problems frequently are unique and differ from the many other problems in a general hospital. We can predict that the nursing profession will make a real contribution to industrial medicine. This is a branch of nursing that requires unusual balance and judgment as well as skillful nursing and kindness. An article in the May issue of the *American Journal of Nursing*, states "In no field of nursing are integrity, sound judgment, and professional maturity more strongly challenged than in industrial medicine." Special training must be provided for nurses in this highly specialized field.

The Connecticut Safety Council is in the same position that we in medicine place departments of health. Their functions are similar. The health departments attempt to prevent all illnesses. The Safety Council is dedicated to the prevention of accidents. It is a noble marriage.

Research must continue. The proper place for this work in Connecticut is in the Industrial Division of Yale University School of Medicine. This is expensive and requires large endowments, and this is a duty of Connecticut industry. I am sure that the industry of now and the future will accept this responsibility, for it will pay large dividends.

Connecticut was one of the first states, if not the first, to provide employment for the physically handicapped. This was a great step forward and redounds to the credit of Connecticut industry, safety, and medicine.

There is another and new phase of work to which we must all contribute. I refer to rehabilitation. The work of Dr. Howard Rusk has made us all conscious of our laxity and weakness. Again industry, nursing, and medicine must join hands in the great endeavor to help people help themselves.

It is proper to discuss some phases of the work of the Manufacturers Association of Connecticut. This association has come hand in hand with the other groups in the advancement of industrial medicine. The advances in the last quarter of a century have been tremendous. We must not stop here. A great attack is being made on voluntary medicine in the United States. Some of the proponents of federal medicine are undoubtedly sincere, if misguided. Some are not. Some are followers of ideologies that are foreign born and that are persistent in their efforts to destroy a free America. They must not be permitted to succeed. If this happens the free and voluntary, and great institutions that we have known must fall. Following this, and as sure as night follows day, transportation, insurance, heavy industries, and utilities will come into their hands. The time has come for industry to realize that, if medicine as we know it goes down, it is the beginning of a day in America that will be black indeed. We should not be fooled by the assertions of these people that they are interested in the common man. It is foolish to believe that the federalization of medicine would give more or better care to the sick. No one in Connecticut is being denied excellent medical care at any time. Medical men are proud of their heritage. They know and are willing to accept the responsibility of caring for the sick, and at any and all times. Industry does not want this interference; the Safety Council does not want it; medicine does not want it. Let us have less and less of subsidies and interference from the federal government and more and more of voluntary agencies.

With the generous cooperation of Connecticut industry, the Safety Council, and industrial medicine the top rung of the ladder can be reached and maintained. The Connecticut State Medical Society assures you of its unalloyed support.

THE MODERN HISTORY OF DIABETES MELLITUS — ITS MANAGEMENT

THOMAS P. MURDOCK, M.D., *Meriden*

THOSE of us fortunate enough to go back to the Allen period of management of diabetes mellitus realize the great changes that have taken place in the management of this disease in the last thirty years.

We recall particularly the low caloric intake and low carbohydrate content in the diet as outlined by Dr. Allen; the undernourished bodies; the frequency of acidosis and coma and tuberculosis. One could frequently make a diagnosis from the history alone. This would be a history of great weight loss—large appetite—passing large amounts of urine and finally acidosis and coma. Or it would mean the same preliminary picture with the development of pulmonary tuberculosis.

And then came the present or modern period which arrived in 1921 with the advent of the so-called regular insulin. With the use of insulin, of course, came a high caloric intake—a gain in weight—the lowering and almost complete abolition of tuberculosis as a complication and the lowering of the incidence of coma. I think it is fair to say, at this time, that if coma does occur, someone is at fault—the patient—the relatives—the doctor. Coma can and should be prevented.

The diabetic of today has the general appearance of one perfectly well and not the appearance of one with an important organic disease. He looks well nourished; his weight is satisfactory; he has good color. It is no longer possible to detect these people as diabetics without reasonably careful study.

Again, those of us fortunate enough or unfortunate enough to have practiced in the pre-insulin days look back with sadness to the management of diabetes mellitus and its complications. It really amounted to standing by and watching these people die. Death in the diabetic who developed acute infections was very high, as was the high mortality

rate in surgical procedures in the diabetic. Coma was a very frequent complication in any condition that threw the metabolism out of line.

The present day diet of the diabetic in general is about the same as for the nondiabetic. Based on about 40 calories per kilogram of body weight and usually containing 2200 to 2500 calories, it gives him all that he requires and almost all that he desires. The usual diet will contain fruit, eggs, bacon, bread, butter, vegetables, meat, fish, potatoes, milk.

The diabetic of today presents a unique, psychological picture. After the diagnosis is established and he is told what the general picture is and what his pattern of life must be, his first question is, doctor will I live? After another week, he asks for more food than he has been given. Finally, he resists insulin. These changes take place in a matter of days.

It has been my experience that practically all diabetics excepting the very, very mild ones require insulin. Almost all diabetics will innocently or carelessly or knowingly violate their diets somewhere along the way. These violations, even though the diabetes is mild, will place an added load on the remaining islands of Langerhans. This results in the almost certain requirement of insulin.

Since 1921 we have had five types of insulin. The original regular and later crystallin insulin, then protamine zinc insulin, globin insulin and now N. P. H. insulin.

The regular and crystallin insulins left much to be desired. They are quick acting, short lasting insulins. Frequency of dosage is the chief criticism. A careful and observing patient was able to notice the daily changes in his metabolism even without hypoglycemic reactions. The immediate lowering of blood sugar followed in about two hours with a gradual rise and a second and third fall during the day as insulin was given. The observing patient

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described the several changes and symptoms occurring with these changes in blood sugar.

Protamine Zinc Insulin, of course, was a great advance and a boon to the diabetic. The disadvantages of protamine, however, were soon apparent. It lacked a quick acting effect and probably the high point of blood sugar was in the few hours immediately following its administration. In the attempt to correct this, in the early days of its use, the dosage was increased and the danger of hypoglycemia during sleep was increased. This resulted in the use of a combination of regular or crystallin insulin and protamine. The common ratio was about 2:1 and was reasonably effective.

Globin insulin was thought to have a place between regular insulin and protamine insulin. It has never impressed me as being a formidable weapon against diabetes or having a prominent place in its management.

N. P. H. insulin apparently is the best of the insulins to date. It is a crystallin insulin with a smaller amount of protamine. It has an immediate effect as well as a delayed effect. It is doubted now that the immediate effect is as satisfactory as was thought in the beginning. Despite this, it certainly has lowered the number of diabetics requiring additional regular or crystallin insulin. At the same time, the prolonged effect carries over to 24-30 hours.

We are still confronted with the occasional allergic manifestations of insulin. These are usually urticarial reactions and may be very annoying and difficult to manage. Our present insulins are made of combinations of beef and pork materials. When reactions occur, the best procedures are to try beef insulin alone, then pork insulin alone. Should reactions occur with both, then desensitization quickly is required after the method of Corcoran.

The diabetic still looks forward to the day when he will be able to take his insulin by mouth. It is a challenge to the biochemist to add to the magnificent history of the management of diabetes.

Pregnancy in the diabetic is not fraught with the dangers present in the pre-insulin days. It is true that the incidence of abortion is high and that the baby of the diabetic mother is frequently a much larger baby—and still births are more frequent than in the nondiabetic. The maternal mortality rate is not any higher than in the nondiabetic group.

It is written that all men must die once, and, of

course, this applies to the diabetic as well as the non-diabetic. At the same time, medicine has been attempting to postpone this and to increase life expectancy.

The study of life expectancy in the diabetic group has been most interesting. In the period immediately preceding the advent of insulin, the life expectancy was about 44 years. Now the life expectancy is about 65 years—the same as for the nondiabetic. Dr. Elliot Joslin has been quoted as saying that in all probability they would outlive their doctors.

In the pre-insulin days, the diabetic frequently faced acidosis, coma and tuberculosis. The danger of coma was greatly increased when diabetes was complicated by acute infections. Necessary surgical procedures also increased the danger of coma. These are not any longer of great significance.

What then does the diabetic die of? He dies of degenerative diseases that are more common in the diabetic than the nondiabetic. Commonly, these are vascular disease, heart disease, nephritis.

These are not infrequently long lasting and associated with great suffering. Coronary disease is a common complication of diabetes. If the diabetic gets by the first attack and develops congestive heart failure, he has before him several years of semi-invalidism and suffering.

Vascular disease represented by retinitis is a serious complication and one of great hardship for and suffering of the patient. Prior to insulin, it was felt that the patient with retinitis would die surely within two years and usually within six months. This does not apply now. These people live for several years and usually are very unhappy because of blurred vision and its necessary restrictions.

The patient with a gangrenous leg or legs also presents a very sad picture. There has been a trend in the past few years toward low amputations. If successful, this is pleasing to the patients. Unfortunately, this is not always successful. In our hands, oscillometric readings have not been as satisfactory as one would like. When depended upon alone and fairly good readings obtained, it has frequently been necessary for the surgeon to do second or third amputations higher up. These are severe psychological insults to the diabetic.

We have had five diabetics who have required bilateral leg amputations. While greatly dependent upon attendants, these people have been reasonably comfortable and happy. The relief of their leg pains

brings them great comfort and happiness. The pain of peripheral vascular disease is severe and constant and is frequently worse at night.

Vascular nephritis is one of the common late complications of diabetes. It is characterized by hypertension, albumin, casts, elevated blood nitrogen and low phenolphthalein. It is also one of the very serious complications and one of the very difficult ones to manage dietetically.

And so in the modern history of diabetes mellitus and its management much has been accomplished. The diabetic looks better. He does not any longer look like a sick man. His weight is maintained or increased. His diet is adequate and might even be called pleasing. In general, his insulin administration has been reduced to once daily. This carries on for several years and then he gets into trouble with the complications we have outlined.

There are those who feel that the well controlled diabetic does not develop vascular complications. Their reports are well documented. Our experience has been just the opposite. Practically all diabetics eventually develop vascular complications. These present themselves in the form of cerebral vascular complications—retinitis—coronary disease—vascular nephritis—peripheral vascular disease.

At this point I would like to say that we have been heretics in relation to our management of diabetics with vascular disease as a complication. Many good clinicians insist on keeping these people absolutely urine sugar free and their blood sugars in normal range. We have felt that this was too fine. Many such people have complained of anginal chest pain when the blood sugar was held in normal range. Many have complained of peculiar head symptoms associated with mild hypoglycemia. To correct this, we have permitted these people to spill a little sugar in the urine and to hold their blood sugars a little above the normal range. In doing this, these disagreeable symptoms have been prevented.

What does all this add up to? It adds up to a challenge to the clinicians, to the physiologists and to the biochemists. At the present time, this challenge points to atherosclerosis and cholesterol. Whether cholesterol alone is the offender is being questioned. It is my feeling that there are one or more additional factors in the picture. What these are is impossible to say.

Several years ago I had the opportunity of studying and caring for a most unusual diabetic. A wealthy Jewish man in his sixties, with moderately

severe diabetes and with the vascular complications which we have mentioned. He had a retinitis; his dentures were unfitting, despite several attempts with new dentures to make them so, and at very great expense; he had arteriosclerotic heart disease; he had a chronic cough, associated with either chronic bronchitis or bronchiectasis; there was a hernia in an old appendix scar, which, when he coughed, he was forced to put pressure over the hernia with his hand to prevent strangulation; he had a hydrocele which had to be tapped once or twice a year; an enlarged prostate required catheterization four times daily; he had only one leg and it was not too good. Later this required amputation. He came through the surgery like a breeze and 48 hours later developed a pulmonary embolus and died. During his period of management, he was given about 20,000 hypodermics. These were accounted for by three injections of regular insulin a day for twelve years. A few bouts of acidosis accounted for many more. Urological consultation resulted in catheterization every six hours rather than surgery. To accomplish this, it was decided to give him 16 mg. of morphine by hypodermic before each catheterization. This went on for almost four years. This accounted for about 5,000 more. He never asked that the dosage or frequency be increased. In one of our discussions he said he was sorry that he had met me, and that insulin had been discovered. If not, he would have gone into coma and have died peacefully and probably without suffering.

This story, I think, explains the thinking of the diabetic. And medicine will not have done its full duty until these complications are prevented, minimized or brought under better control.

And so in controlling this disease and prolonging the lives of these people, we demand in payment that they develop other diseases which are much more painful and much more disabling and diseases from which they must eventually die. This, then, is the challenge before us and one that we must accept and conquer, if we are to do our full duty to mankind. It is probably one of the most difficult problems that medicine has faced. To do this will require careful clinical observation and careful research. It is the duty of all clinicians to be very observing, so that the physiologists, biochemists and pharmacologists will be given leads that will help. It is my feeling that medicine will accept the challenge and accomplish the result. When this is accomplished, in my opinion, it will be one of the very great advancements in medicine, if not its greatest.

COOPERATION BETWEEN PRACTITIONERS OF MEDICINE AND PUBLIC HEALTH OFFICERS

THOMAS P. MURDOCK, M.D., *Meriden*

FIRST, let me say that I am grateful for the invitation to give this address and for the opportunity of discussing some of the common problems of practitioners of medicine and public health officers. I must say, at this time, that any statements I make are my own and must not be considered as statements coming from the American Medical Association or its Board of Trustees.

During almost half a century of medical practice, and I might add, without being egotistical, a large practice, I have come to know some of the common problems of medical practitioners and public health officers on the local level. In recent years, through contacts and associations with other groups in the healing arts on state and national levels, I have come to see the problem on a much wider plane. The interesting thing about this broad viewpoint is that the same basic problems seem to exist. The same basic mistakes seem to be made on both sides. The same careless statements seem to be made.

We know, and it is basically sound, that there is never a result without a cause, even though in the sciences that cause is sometimes found very late and sometimes not for centuries. One asks, what are the causes of some of these basic mistakes and careless statements?

My personal contacts with public health officers go back to the beginning of the second decade of this century. Their functions and duties in that era were concerned almost entirely with contagious and infectious diseases and with sanitation. The chief duty of the public health officer in this period was largely that of quarantine officer. Only the larger cities had full-time health officers and health departments. The chief duty of the public health officer now remains the same as at that time, namely, the protection of the health of the people.

Since then, a great change in the functions of the public health officer has taken place. The field now covers many of the long-duration illnesses, such as rheumatic fever, chronic arthritis, cancer, syphilis, and diabetes, and care of crippled children and the blind. One could also ask at this point, how did this change come about? What are some of the reasons for the change? Is this change healthy and sound? Are there any dangers in this change? Long-duration illness is never dramatic; termination by death is frequently prayed for by relatives and friends. It is trying on both the patients and relatives, and it is expensive. The results are often bad. On the other hand, acute surgical conditions are frequently of short duration; the drama of the operating room, of anesthesia, of surgical specimens is present. It gives the patient something to talk about at drawing room parties for months to come; whereas with long-duration illness, the commonest drawing room statement is, "It is a pity he can't die."

The philosophy of the American people is changing and has changed considerably in the last two decades. A close observer will notice that there is an unwillingness on the part of children to assume their responsibilities in the care of parents or relatives. They seem to feel that they have done their full duty when they have placed these unfortunate sick and elderly persons in homes for the infirm and aged, frequently at the expense of others.

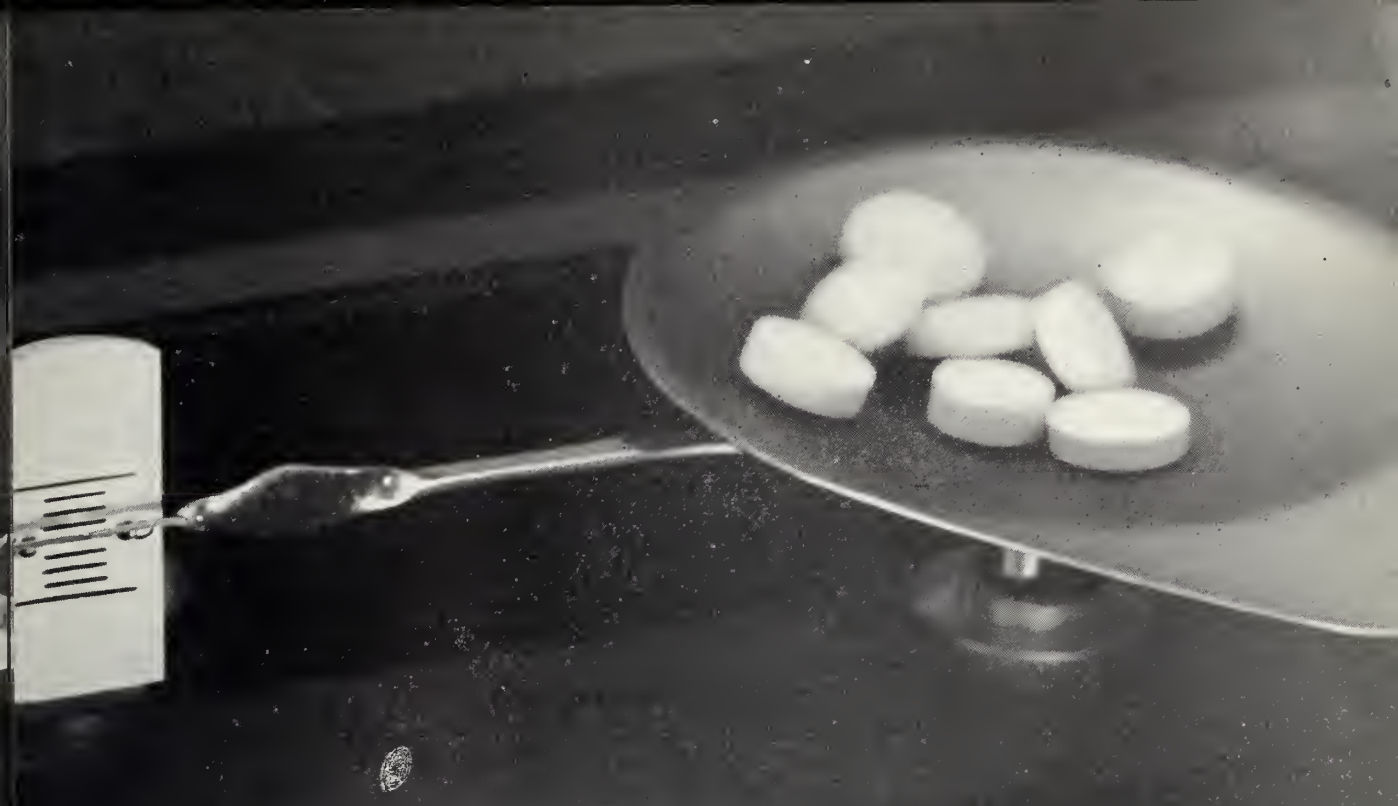
When federal funds are to be channeled into the states, it is done frequently through state health departments as established units of government. How did this come about? I think the answer is clear. On the national level, we have the United States Public Health Service. This was, and is, a fixed unit of the federal government and actually is the chief organization concerned with civilian

Read before the meeting of the Association of State and Territorial Health Officers, December 10, 1952, Washington, D. C. Reprinted from Journal of American Medical Association, February 14, 1953 with permission of the editor



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1. Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: *Antibiot. Med. & Clin. Ther.* 3:378 (Nov.) 1956.

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health. On the state level, we have a similar situation with state health departments, which are fixed units of state government and, again, are the chief, if not the only, ones concerned with civilian health. Few states have medical care authorities. It is natural, therefore, that federal bills should endow the United States Public Health Service with this power and that, in turn, the state health departments would function similarly on the state level. This change could be accepted as healthy and sound if both groups focused their attention on one basic danger. The function of the practitioner is the care of individual sick persons, and the function of the public health officer is the prevention of illness in the community. If either function is usurped, trouble develops.

I know that the Association of State and Territorial Health Officers, as such, has been in existence since 1912, and I know that meetings with the United States Public Health Service have been going on for a longer period. That is good for public health officers and for public health. I can say at this point that America is fortunate, the public health service is fortunate, and public health officers are fortunate in the selection of Leonard Scheele as the Surgeon General of the United States Public Health Service. I am sure that the annual meetings of state health officers, with the exchange of ideas, discussion of the different state sanitary codes, and explanations of the different departments in the various state health departments are productive of great good. I think I detect one weakness. Is any attempt being made to bring this information down to the subordinates in the state health departments or to the municipal health officers? Unless this is done, some of this effort probably is being wasted.

It is difficult for the uninitiated to recall the differences between the various public health organizations. These are the United States Public Health Service, the American Public Health Association, the Association of State and Territorial Health Officers, the Association of Schools of Public Health, and the National Organization for Public Health Nursing. There probably are others, and I am told that another public health organization is in the making. Are these separate organizations necessary? I realize that it would probably be difficult to unite them because of their different purposes. Is there liaison between them? I think this is important.

We could all take advice and guidance from the

recent action of the various nurses organizations. Formerly, there were six rather large groups. In the recent reorganization, they were combined into two great organizations: (1) the American Nurses Association, with membership made up of individual nurses, and (2) the National League of Nursing, which is subdivided into (a) the National League of Nursing Education and the National Organization for Public Health Nursing and (b) Hospital Nursing.

The Commission on Chronic Illness has been reorganized. This organization was founded jointly by the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association. It is being financed by several organizations, many of which are concerned with chronic illness. This commission got off to a bad start about three years ago because of limited funds, a director loaned for only a year, insecure policy, and lack of direction, stimulation, and drive. It is going well now. The director is Dr. Dean Roberts, formerly with the Maryland State Health Department. An urban study is being conducted in Baltimore, and this work is to be finished within five years, possibly within three. A suburban study is being carried on in Hunterden County, N. J. The Chronic Illness Commission is acting in an advisory capacity in the New Jersey study. It is my belief that much valuable information will come from both studies. A survey of nursing homes is to be done within the next year by the Commission on Chronic Illness. Here, I think, is a place where the state health departments can be of great help. Also, a conference on the care of the chronically ill is to come up during the next year, another place where public health organizations can help.

The National Health Council has just come up with a report of the program development committee. This is to be a continuing committee with recommendations for changes or improvement as conditions warrant. My thought of the chief function of the National Health Council is that it should be the great coordinator of the functions of the various member organizations. Owing to lack of funds, it has been forced to limit its program.

The Inter-Association Committee on Health is made up of representatives of the American Hospital Association, the American Medical Association, the American Dental Association, the American Public Welfare Association, the American Public

Health Association, and the American Nurses Association. The representatives are officers of the various parent organizations. The chief purpose of this organization is to try to resolve the problems common to all. It is the feeling of some, and to this I subscribe, that this organization is not workable or practical.

I believe there are now 11 schools of public health in this country. One closed recently, and I am told that another is about to do so. The public health schools now in existence have less than 1,000 students. The schools are having the same financial difficulties that all medical schools have. It is my feeling that ways and means must be found, on a voluntary basis, to relieve the financial situation and to stimulate enrollment.

Are there differences of opinion between public health officials and practitioners of medicine? Have tensions developed between the two groups? Are there criticisms from both sides? Have there been careless statements made on both sides? Can these differences and tensions be resolved? My answer is yes to each of these questions, especially so for the last one.

I think it is fair to say that these differences begin with the fact that one group has chosen to enter full-time government service, whereas the other group has chosen the way of caring for the individual sick or injured persons on an individual basis or group basis. This immediately poses not an immediate change in philosophy but a difference in procedure. The full-time worker, viewing it from a material standpoint, has a regular salary, with gradual increases and a retirement fund. It is true, probably, that his income is not as great as the practitioner's income. The practitioner, on the other hand, gambles on the question of his ability to prove to individual persons that he is a well equipped physician and is deserving of their patronage. During this period, their thinking becomes widely separated and their social viewpoints differ. It is here that a change in philosophy takes place. At this point it would be well for both to remember that their duties are the same, namely, the care of the sick and the prevention of illness. Perhaps you may have wondered why I have devoted so much time to the question of chronic illness in relation to public health officers and practitioners of medicine. This, too, I think, is one of the important causes of the differences of opinion.

Are practitioners of medicine familiar with the

problems of the state and territorial health officers? Are the health officers familiar with the problems of the practitioners? My answer to these questions is no. It has often occurred to me that this would be a sad country without efficient state health departments. By the same token, it would be equally sad without efficient practitioners of medicine.

I can say with certainty that, during 40 years of practice, I have never known one person to be denied adequate medical care. All patients are entitled to medical care, and American practitioners will see that they get it. This will be done on a private contractual basis between the physician and the patient or willingly without fee where the need can be shown. This latter must be watched and guided, however, because it is fraught with danger if done unnecessarily or unwisely. Then it is only a short step to socialism. We all have seen the results of fascistic medicine in Germany and communistic medicine in Russia. What the future holds for England, God alone knows, but the most optimistic are sad. Thus, we have, as the crucial factors in the problem, chronic illness and cases in which the need can be shown. To these, of course, must be added a difference in procedure in practice and, later, a change in philosophy between the practitioners and the full-time state officers.

I have heard it said that in the various public health organizations there are minority groups who are "left of center" in social philosophy and that these groups are very vocal; their attitudes and actions are responsible for the labeling of all public health organizations as left of center. This is unfortunate. I think I can say that the large majority of practitioners do not subscribe to this point of view. The American Medical Association, in its statement of policies, has endorsed public health services to the end that all areas would profit by them. At the same time, I need not tell you of the accusations made and attacks against the American Medical Association. You are all familiar with these.

I am opposed to compulsory nationalized medicine. I am a firm believer in the voluntary insurance way, on a state level. The question of compulsory nationalized medicine would be the place, I am sure, where the socializers would attempt to divide us. This is what occurred in Great Britain when the general practitioners and the specialists were divided. It must not occur in the United States. What can be done to correct this situation, if such a situation exists? I think we ought to face the fact

that it does exist and not bandy words about it but attempt to correct it.

I think there are those among both public health officers and practitioners of medicine who have been intolerant. I think, however, that the promoters of these intolerances have been and are in the minority and that the great majority in both groups are anxious and willing to see the viewpoints of the other group. Intolerances, whether they be on a racial, religious, or professional basis, have no place in American life. It would be splendid, I think, if each group recognized and understood the legal and moral responsibilities of the other. It would be to the advantage of both if the practitioner of medicine had experience and work with a health department. By the same token, it would be equally advantageous if health department officials had experience in general practice before going into public health service. Obviously, the work of a local or state health department would be nullified without the cooperation of the practitioners. At the same time, there are many things a state health department can do for the practitioner and the practitioner's patients.

The American Medical Association recognizes the necessity of the various specialties for their own sections at its scientific meetings. It also recognizes the necessity of special associations or organizations not only for the good of the organizations but also for the good of the public in the care of the sick and the prevention of illness. It also recognizes its responsibility to ethically guide its members as does the church in its guidance of its children.

I think it would be a wise move on the part of the

State and Territorial Health Officers Association to arrange specific liaison with the American Medical Association. The American Medical Association has a Section of Public Health and the State and Territorial Health Officers Association is well represented, but this would go far beyond that and, I am sure, could be accomplished. The common problems, and there are many of them, could be resolved in this way on the national level. In this way, the State and Territorial Health Officers Association would become more closely associated with its parent organization, or what I believe should be considered its parent organization. In following through with this program, I think it would be wise for those states not having state liaison committees for this purpose to arrange to have them. Most men are fair, understanding, willing to see the viewpoint of another, and tolerant. It is only the few who are not. When two groups sit around a table to discuss a controversial problem, almost invariably they will come up with the solution.

The State and Territorial Health Officers Association has had a long and successful life. It has made great contributions to life and to humanity. It must continue to do so. My sincere congratulations go out to this organization.

In conclusion may I say that I know of no organization, if it be not the church, whose basic principle is more fundamental, sincere, noble, and unselfish than is that of the American Medical Association. That basic principle is "to promote the science and the art of medicine and the betterment of public health." The State and Territorial Health Officers Association exists for the same purpose.

CARDIOVASCULAR DISEASE AS A NATIONAL HEALTH PROBLEM

THOMAS P. MURDOCK, M.D., *Meriden*

I THINK you have selected wisely for this session limiting the discussion to Diabetes Mellitus, Cancer and Heart Disease. Of these three, probably the greatest destroyer, in numbers at least, is heart disease. This disease has prominence in early and late life, and in altogether too great frequency.

One of the very sad pictures in medicine is to see the child with congenital heart disease. Another is to see the child with rheumatic fever followed by rheumatic heart disease. It is hard when one can visualize the future for these children with either of these conditions.

It is probably impossible to determine the number of children born with congenital heart disease. It is known that of 5,000 registrants in World War II who were re-examined because of the question of heart disease that 4.5 per cent were found to have congenital heart disease. The disease is probably more widespread than has been thought in the past. It is also accepted now that a mother developing rubella in the first trimester of pregnancy will deliver a sizeable percentage of children with congenital defects, including congenital heart disease. The same is true, but to a lesser degree, in the second trimester of pregnancy.

Rheumatic heart disease is the commonest form of heart disease occurring in childhood and young adult life. About 50 per cent of rheumatic heart disease occurs before 30 years of age.

And so at this point we can stop for a moment and say that two of the greatest destroyers of childhood and young adult life are congenital disease and rheumatic heart disease. Here then must our research studies begin toward the end of prevention. This must be done if these young people are to be saved from early long duration illness and if they are to be made useful members of society.

Another step along the way which adds to the number of people with chronic heart disease, and

one which is directly attached to rheumatic heart disease and congenital heart disease is subacute bacterial endocarditis.

I think it is a fair estimate that 90 to 95 per cent of these cases are due to non-hemolytic streptococcus—*streptococcus viridans*. Gram negative bacilli and gonococci probably represent the remaining five to 10 per cent. These organisms are superimposed on an already damaged endocardium.

This disease of itself is a disease of long duration and comes under the heading of chronic heart disease. Not infrequently the disease will last from several months to a year or more.

Prior to the advent of the antibiotics practically all of these people died of their disease. A few cases probably of doubtful diagnosis have been reported as cured.

Unfortunately the feeling persists that it is unwise to make this diagnosis until a positive blood culture has been obtained. Various estimates have been made as to the ease or difficulty of obtaining a positive blood culture. This varies from 25 per cent to 90 per cent. If we take the lower limit, we are denying a large number of these people the possibility of cure.

Given a patient with a history of rheumatic heart disease or congenital heart disease, unexplained fever, petechiae, heart murmur, palpable spleen, leucocytosis and rapid sedimentation rate with or without positive blood culture, I think it is sound to make a diagnosis of subacute bacterial endocarditis.

In the early days of the use of the antibiotics it was common practice and probably still is in some clinics to give one of the anticoagulants in conjunction with penicillin. I don't think this is any longer necessary.

Where a positive blood culture can be obtained sensitivity tests can be made and the value of the

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antibiotics determined. Where this is not possible, trial and error must be used.

It is now accepted that when the diagnosis is made reasonably early that a large percentage can be cured of this disease. And this is where we again are faced with a sad situation. We have cured the patient of his subacute bacterial endocarditis—but where does this leave him? He already has his damaged heart from rheumatic heart disease plus the damage from his superimposed subacute bacterial endocarditis. He now, of course, is worse off than he was before he developed subacute bacterial endocarditis. He now has full blown chronic heart disease and faces another period of long duration illness. Frankly the answer to this long series of illnesses rests only in the prevention of rheumatic heart disease and congenital heart disease.

We now leave this sad situation with the hope that soon will come the answer of prevention, and move on to the later decades of life where due to stress and strain again we face the condition of chronic vascular disease and heart disease.

A great many years ago, Herrick in his description of vascular disease stated that one could draw a triangle and on one side write heart disease, on another vascular disease, on the last kidney disease. He stated that you could stand the triangle on any base and the other diseases would follow. I don't think that there is any doubt but that opinion holds today. Later on, Winteritz labelled these under the heading of vascular diseases.

The question of essential hypertension comes next. Those who have had an opportunity to see a great many people with hypertension now feel that there is a definite hereditary factor. When this condition is found, a careful family history will frequently bring out this fact.

There are those who feel that in almost every instance a primary cause can be found. The work of Page and his co-workers have brought out the question of renin and angiotonin as pressor factors. Goldblatt has produced renal ischemia and hypertension by clamping the renal artery.

We must never overlook the strains and stresses of our modern life as causes of hypertension. Again those who have had the opportunity to observe many of these people before and without hypertension and have seen them after tensions or stresses can date the hypertension from that time.

The fact remains, however, that whatever the

causes may be, hypertension eventually produced changes in the heart, blood vessels and kidneys.

The next step of course in this picture is the question of arteriosclerosis. It is accepted that it not infrequently follows hypertension. Much attention is being given at this time to the study of cholesterol in its relation to atherosclerosis. That it is a contributory factor, there seems little doubt—but that it is the whole factor there is probably grave doubt.

Despite the fact that this does not come within my province today, I am emboldened to say that the diabetic seldom gets into difficulty with his diabetes as such, but does get into serious difficulty with the complication of atherosclerosis or arteriosclerosis.

These two factors of hypertension and arteriosclerosis are responsible for 25 to 40 per cent of chronic heart disease and arteriosclerotic heart disease is one of the commonest causes of death.

The symptoms and signs of arteriosclerotic heart disease are those of angina pectoris, with chest pain particularly on effort, shortness of breath, disorders of conduction mechanism, and later the other manifestations of congestive heart failure.

A word should be said here about coronary thrombosis and its relationship to chronic heart disease. There are those who now advise the term myocardial infarction. It is my feeling that it will be hard to displace the term coronary thrombosis.

The symptoms and signs are well known with sudden onset of crushing substernal pain—frequently with radiation to shoulder or neck—rapid and frequently irregular heart, shock, elevation of temperature with increased leucocytes and rapid sedimentation rate.

About 80 per cent of these people survive the first attack, but death occurs with succeeding attacks or from congestive heart failure and many within five years. A few are able to return to their previous occupations, but many become chronic heart invalids.

These various people with hypertension, arteriosclerotic and coronary heart disease eventually develop congestive heart failure and become subjects of chronic heart disease with which we are particularly interested today.

Congestive heart failure means breathlessness, weakness, edema, abdominal discomfort, palpitation and precordial distress. In a word, they are subjects of a serious chronic disabling disease. The manage-

ment and care of these unfortunate people is one of the very important and challenging situations placed before American medicine today.

The burden on the heart must be lessened. It is frequently necessary to restrict the activities of these people to a marked degree. Almost always it is necessary that they be relieved of any work activities. In the beginning this is frequently difficult because of the economic picture. They should be kept at home as long as possible. Then if necessary in a general hospital and finally if necessary in a home for cardiac invalids.

The heart muscle efficiency should be improved with digitalis. I think it is probably wise with older people in congestive heart failure to slowly digitalize them. Later, of course, maintenance digitalis is required. Edema should be relieved with salt restriction and the judicious use of the mercurial diuretics. Sedatives, hypnotics and opiates are of great help in these people. They are usually apprehensive and fearful and sleep must be induced.

And so here today we are faced with a discussion

of one of the many and perhaps the most frequent and important of the chronic illnesses. It is one of the serious challenges facing American medicine.

All men must die once, and it is only natural that an organ so important as the heart should be attacked as the result of the wear and tear processes of life.

We have the right here to ask can this problem ever be completely erased? My own feeling is that it cannot. At the same time, I feel that we can postpone this even if we feel that it is eventually inevitable.

My thought is that research should be directed toward removing stresses and strains, toward postponement of arteriosclerosis, toward the prevention of rheumatic heart disease and congenital heart disease.

When and if these diseases develop, to see to it that these people are given adequate, scientific, kindly care at home, in a general hospital or an infirmary type of home for the care of cardiac patients. Until we have done this, we will not have done our full duty to mankind.

TEAMWORK IN PUBLIC HEALTH

THOMAS P. MURDOCK, M.D., *Meriden*

SUMMARY

The base line of Public Health has been greatly widened to cover almost every phase of the healing arts. There is a feeling on the part of some physicians that the Public Health Officers have usurped the position of the practitioner in the chronic illness program. The increasing prominence of nurses and social service workers in the Public Health field may create difficulties. Such conflicts must be solved. Voluntary practice must not be crowded out by federal programs.

Tolerance on the part of the physician and of the Health Officer is urged as well as care in the selection of personnel by Health Officers at the top level. The care of the sick is the common purpose of both physician and Health Officer.

IN THE beginning let me say that despite a very heavy and tight schedule I am grateful for the opportunity of participating in this discussion. I come here as a private practitioner of medicine and not as a member of the Board of Trustees of the American Medical Association. In the past few years, however, I have begun to wonder whether or not I am a private practitioner of medicine.

Last December I was privileged to address the National Association of State and Territorial Health Officers in Washington, D. C. At that time I stated that I detected a weakness in their program in that there were no avenues available for bringing their programs or the results of their programs to the state level and if there were none, some of their efforts were being wasted. And so today I am par-

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ticularly pleased with this program and your efforts.

I am sure you realize, as I do, that there are some practitioners who feel that the Public Health officers have usurped some of their prerogatives. In some instances this is probably true, in general probably not.

It is now known, recognized, and even might I say accepted that the base line of Public Health has been greatly widened. At the turn of the century the duties of the Public Health Officer were those of quarantine officer and sanitary officer. The field now covers almost every phase of the healing arts as your program indicates today—and includes medical, dental, nursing, and social service coverage.

In the medical field practically all of the chronic illnesses are included. At once I think of chronic arthritis, cancer, rheumatic fever, syphilis, diabetes, crippled children and several others. This makes the situation particularly dangerous and tends to increase the tensions between the Public Health officers and the physicians. Some practitioners are bound to say that the Health Officers have usurped their position. The fact is that when Federal funds are to be allocated for these purposes, the chief, if not the only Federal allocating authority, is the United States Public Health Service and in most of the states, the only allocating authority is the State Department of Health. Because of this set up, rules and regulations are formulated at the top, and the implementation is accomplished at the state level. The fitness of things at the local level are frequently different, and this makes for trouble.

During the past year the dispensation of gamma globulin was added as one of the duties of the Public Health officers. As you know, there was thought to be a shortage of this material in this country. I happen to have been a member of the National Allocation Committee, actually a subcommittee of the National Research Council. It looks, at this time, as though there will be a surplus when the severe polio season is over rather than a shortage. I was opposed to this additional burden on the Health Officers because it immediately placed the Health Departments on the spot. My opposition also was based on the fact that confusion still exists as to the best method of application. There are those who believe that mass immunization alone is effective, while others believe that the best approach is by attempting to stimulate antibodies of intimate contacts. Time alone will probably tell which is the proper approach.

I have great respect for American nurses and this, of course, includes the Public Health nurses. Public Health nursing standards are high and should be kept so. They have filled a prominent place in the healing arts team. Here again I detect the beginnings of some rows between the different grades of nurses, and between the physicians and the nurses. These differences must be recognized and solved if we are to avoid continued bickering.

The Social Service worker, and more particularly the medical Social Service worker, is relatively new in the health field. If the philosophy behind this service is sound, and I believe it is, there will be greater opportunities for young women in this field than ever before due to increasing life expectancy and to increasing numbers of people with long duration illness. However, there is danger here also, and I have heard Social Service workers called meddlers. This is unfortunate because I believe they have a definite place on the modern healing arts team. However, they should be carefully selected and have a thorough knowledge of medical ethics.

You must not think that I have gone beyond my allotment in this program, by touching briefly on nursing and social service workers. Actually, I have done so purposely to bring out possible dangers.

As I view it, from here on the Public Health Officer is on dangerous ground. He must carry a greater load than ever before and over places where the ice is very thin. First—the conflicts that may develop between the physicians and the Public Health Service—these should be prevented if possible. Second—there is danger of creeping socialism or creeping nationalism if the Public Health Service is not wisely administered. American medicine should not, and I am sure will not, give up on the question of voluntary practice. Medical care by compulsion would be intolerable.

The American Medical Association has taken the stand that it is proper for the state to provide a subsidy for a long duration illness and, in the case of veterans, for the federal government to do it until the various states can make such provisions. I am in complete agreement with this position.

I make two major recommendations: first, tolerance on both sides. The practitioner not to attempt usurpation of the Health Officers field and the Health Officer not to usurp the field of the practitioner. There is room and there are places for both. Secondly, very great care should be used by Health Officers at the top level in the selection of the per-

sonnel below. This, I believe, is extremely important. If the field officer, who has contact with the physician directly, is intolerant or officious, a breakdown in public relations takes place and this widens the breach. If these two points are followed, a great many differences will fade or will not appear. After all, our purposes go hand in hand, namely, the care of the sick and the prevention of disease.

The time has come, I believe, when greater stress must be placed on these problems in our medical schools and in our Public Health schools. A great many of the differences will be prevented if this can be accomplished. Also if the practitioner had a clearer concept of the duties of the Health Officer and the Health Officer a clearer concept of the physician's position, these difficulties could be prevented. This applies particularly to those who are new in the healing arts field. Those of us in the evenings of our days can be safely ignored.

Here in Connecticut we are very fortunate in having as our present State Health Commissioner, Dr. Stanley Osborn. We are equally fortunate in having Dr. Ira Hiscock as head of the Public Health School at Yale University. Both have had very close contact with the practitioners in this State and, probably because of this, our problems and differences have been minimal. You must remember, however, that I am somewhat biased because both of these men have been my very close friends down through the years.

Finally, our purposes and aims are the same, namely, the care of the sick, the prevention of illness and the betterment of public health. I am sure that any of the other professions or businesses in life would give all for such noble basic purposes. Let us continue to work together here in Connecticut, and carve pattern that will blaze a trail for the other states.

CHRONIC ILLNESS

THOMAS P. MURDOCK, M.D., *Meriden*

MEDICAL men and medical organizations, whether or not they be in the field of Public Health, the Specialties or General Practice, have always faced important medical problems squarely. I believe that American medicine will face the question of chronic illness squarely and that eventually the prevention and management of the problem will be greatly improved, if not perfected.

I class the question of chronic disease as one of the very important medical problems of the day. The management of this very important phase of medicine must and will be improved. This must include research as to the causes and prevention and improvement in care after the disease has developed.

The term chronic disease is entitled to a word of explanation. A specific definition is really very hard to make unless the term is broken down. I think for our purposes here today, it would be wise if we thought of the term as nondisabling chronic disease,

and semipermanent or permanently disabling chronic disease. I think this is important because there are many people with chronic diseases who are carrying a reasonably heavy schedule, and are conforming to advice, and in this way doing reasonably well. These people do not present a difficult problem. The real hard problem is in the prevention of disabling illnesses and in their management after they have become disabling.

Life expectancy since the turn of the century has increased from about forty-nine years to sixty-seven years. I think we all feel that this will be increased within the next few years. A large part of this increase in expectancy has been contributed by the forgotten man in medicine—the pediatrician. This has been accomplished by the advances in infant feeding—immunization against scarlet fever—diphtheria—whooping cough and modifying measles. A tribute should be paid the pediatricians.

Delivered in 1953

July, 1957

With the increase in life expectancy, we must face a very important present fact and that is the question of cerebral arteriosclerosis. All attempts to increase life expectancy should be made with the thought in mind that advanced cerebral arteriosclerosis should be prevented or at least postponed if possible. It is a very sad sight to see men in advanced years with otherwise reasonably good organic structures, and to see them horribly confused. In other words, it is unfortunate to see the brain die before the rest of the body. These people present one of the very sad situations in medicine today.

The list of chronic degenerative diseases probably would depend on who is to draw the list. The general practitioner and the internist would draw one list, the public health worker another, the psychiatrist another, the orthopedist another.

Since the advent of the antibiotics, the surgeons chief interest in chronic disease is in carcinoma and carcinomatosis. Other chronic illnesses which he faced with grave doubts in the past will now frequently respond to surgical management and the antibiotics. Management of acute surgical conditions in the aged or in patients with chronic disease is no longer the problem that it was as late as a decade ago.

The orthopedist continues to have a very important place in the care and management of people with chronic bone diseases. To this must be added the importance of fractures in the aged. One cannot be too careful in the attempt to prevent fractures in this group. This is much more common than it should be and our efforts in prevention should be very active.

If we accept present day statistics regarding chronic illness, we must place psychiatric problems high on our list. This is particularly true regarding long term psychiatric problems occurring in young people. Here is a place where research is definitely indicated in the attempt to prevent long term psychiatric illnesses, particularly in the young. The psychiatrists are already on record as stating that there are not enough psychiatrists available to take care of the ever increasing number of psychiatric patients due to increasing tensions. The answer is research, to the end that many of these psychiatric problems will be prevented.

The vast majority of chronic disease problems will be managed primarily by the general practitioner and the internist. This is a challenge which

we must accept, solve and conquer if we are to do our full duty to society.

The general list that I think of are carcinomatosis, psychiatric problems, long term orthopedic problems, rheumatic fever and its complications, chronic disabling pulmonary diseases, disabling vascular diseases including heart and kidney diseases, diabetes mellitus and its complications, anterior poliomyelitis, muscular dystrophies, cerebral palsy.

Our watch words should be prevention and postponement. These are probably the most important terms in American medicine today. If we are able to accomplish either to a degree, we will make a great contribution to American medicine and to life.

The hereditary factor undoubtedly plays an important part in diabetes mellitus. Family history as to tendencies plays a very important place in vascular diseases when the tendency factor is known. It is my considered opinion that diabetes can frequently be prevented or postponed in the potential diabetic when the weight is kept about ten per cent below normal and when the diet does not put too great a strain on the islands of Langerhans. By the same token with restrictions of physical and mental strain and with reasonable restriction of diet, vascular diseases can at least be postponed.

The American Geriatric Society and the *American Journal of Geriatrics* I believe are making real contributions in the field of chronic disease in the aged. Their watch words are prevention before and management after the disabling diseases have moved in.

After the disabling disease has developed in older people, I would warn you of a few basic principles. Do not change the mode of living or the pattern of life of these people too much. If you inject too many don'ts, they will violate all of them. Do not change their diets too radically or again they will violate all. I think it was Dr. Roger Lee of Boston writing on the care of the aged who said "the three indispensables in the management of these people and in the order of their importance are whiskey, flattery, and milk."

Much advanced work has been and is being done on poliomyelitis. One of the very great organizations in this country is the National Foundation for Infantile Paralysis. The Medical Advisory Board to the Polio Foundation is doing splendid work. The grants for Research, for Fellowships and After Care

have been enormous and at the same time wisely selected. I think that it is not too much to expect that the cause and methods of immunization will be found within the next decade.

In much the same manner, the organizations studying and helping in the questions of Cerebral Palsy and the Muscular Dystrophies are to be congratulated for their work and interest in these very trying situations. The American Heart Association is doing a very fine job not only in the general subject of heart disease, but specifically in rheumatic fever.

The Chronic Illness Commission has been reorganized and will soon be underway again. This organization was started about three years ago. Due to several unfortunate conditions, the organization probably never got well started and bogged down badly. Some of the contributing organizations now have taken an active interest and beginning July 1 a new start will be made. Several of the contributing organizations are those directly concerned with studies in specific chronic diseases.

The investigation of the various phases of chronic illness by the Chronic Illness Commission will be made in two areas. The suburban study is being done in Hunterdon County, New Jersey. This has been undertaken by the Hunterdon County Medical Center, The Chronic Illness Commission, and the New Jersey State Health Department. The Commonwealth Fund has made a sizeable grant for this project. The report will be ready in about two years. The Chronic Illness Commission has acted in an advisory capacity in this study. The urban study will be done in Baltimore and will be conducted by the Chronic Illness Commission. Cooperation and aid will come from the Maryland State Health Department.

The headquarters of the Commission will be in Baltimore. Dr. Dean Roberts will be the active administrator. The Commission plans to finish its work in five years and it is hoped that this can be accomplished in three years. I believe a great deal of valuable information will come from these studies.

The American Medical Association is very much interested in this problem through its Council on Medical Service. The Board of Trustees has made a very sizeable financial contribution to the Commission on Chronic Illness and is represented on its Board of Directors and the Executive Committee.

Until we have reached the maximum of success in the prevention of chronic disabling diseases, we

must make provision for an increasing number of hospitals for chronic diseases, convalescent homes and infirmaries for their care.

In addition to this, moral education of relatives and friends must be undertaken. There has been a tendency of children away from the moral responsibility for the care of parents with chronic disabling illnesses and a tendency away from the moral responsibility of relatives and friends for this group. I think this is due to the changing philosophy that has come to the American people. This must be corrected if these unfortunate people are to be given the care, attention and love which they deserve.

Dr. E. M. Bluestone in a paper in the *Journal of the American Medical Association* in 1947 stated that the majority of these people belonged in a general hospital. That a minority could be kept in their own homes, and that a minority due to scarring would require long term care in an institution. I feel that I would have to reverse this and say that a minority should be kept in a general hospital, and that the majority should be cared for at home, and those with permanent scarring and unmanageable at home be cared for in an institutional type of home. These are also probably in the minority.

One can ask, has the federal government a place in the direct care of these people with chronic disabling illnesses? It is my personal feeling that the answer is no. I doubt that anybody in Washington is as fitted as the people of Oklahoma to determine the type of care that will be given its people with chronic disabling illnesses in this State.

The municipalities and the States have a definite position in this problem. They have done and are doing good work with these disabling problems. I feel that if we must have legislative aid, that aid should be on a state and local level and not a federal level.

Some voluntary hospital plans and some of the large insurance companies are now covering long duration illness. It is my feeling that many of them can be cared for in this way. This type of insurance is relatively inexpensive. I cannot become too disturbed about the expense of short duration illnesses in general hospitals. As I view it, the true type of catastrophic illness is the long duration illness. The expense is great. The loss to the patient and the hospital is frequently more than either can stand. Greater effort should be made to call to the atten-

tion of the American people the availability of this type of insurance.

Dr. Louis A. Bauer, the president of the American Medical Association, is on record calling upon the voluntary hospital plans for a widening of their coverage to include long duration illness. It is hoped that the voluntary plans will soon be able to do this.

And so in the management of chronic disabling diseases, I feel that these problems can be handled. There must, however, be an improvement and change in the moral philosophy of relatives and friends. There must be a willingness on the part of these people to make the necessary sacrifices. This care can be provided in most instances in the home, a minority in a general hospital and the remainder in

an institutional type of home. I feel that Blue Cross and Blue Shield and private insurance companies can and are making definite contributions to the economic picture. I feel that the municipalities and the State have definite places in handling these situations.

Research, research and again research should be stressed toward the end of prevention or postponement. I feel that we probably have been too complacent in the past in accepting these problems as inevitable. It is not too late to start now in our studies of prevention.

Great good can come from this and similar forums. I congratulate you on your willingness to face this problem and in planning this forum.

ADMINISTRATION — NURSING — MEDICAL STAFF

THOMAS P. MURDOCK, M.D., *Meriden*

IN 1947 the President of the American Medical Association, Dr. Edward L. Bortz, on the recommendation of the House of Delegates, appointed a committee to study the nursing problem in the United States with particular reference to the nursing shortage.

The members of the original committee were Drs. Warren Draper, Howard Gray, Leland McKittrick, Donald Smelzer and T. P. Murdock, chairman.

I think it is fair to say that at that time the other members of the committee had only a general and not an intimate knowledge of the magnitude of the problem. I know it is more than safe to say that the chairman probably knew less about the nursing problem than any man in America. He was soon to learn far more than he had planned or gambled on.

The study was an intensive and exhaustive one. During the year, many meetings were held with representatives of the American Nurses Association, the American Hospital Association, the American College of Surgeons and the American Medical Association.

These meetings were held separately with the representatives of the various organizations and

finally meetings with representatives of all of the organizations together. In the beginning it was quickly noticeable that there was an air of suspicion on the part of the representatives of each toward the representatives of the others. A humorous incident took place at one of the meetings where each group was sitting around a large table and not talking to the others. Later when it was recognized that most of the problems were common ones and that each group had an interest, that suspicion was abolished.

Soon after the beginning of the study letters began to come in from doctors and hospital administrators condemning the actions of the nurses. The tone of these letters was in general severely critical of the nurses.

About this time publicity was given to the study and then the letters from nurses began to arrive. They in turn were critical of the doctors and hospital administrators and, of course, the committee. Some were signed and some anonymous. The ones critical of the committee were great. In substance, they said that the committee could be better occupied by investigating the shortcomings of the members of the medical profession and to leave the nurses alone. In both instances it was a lack of understand-

Read at the Catholic Hospital Association of the U. S. and Canada in Cleveland on May 27, 1952

ing. Unfortunately, I believe that some such feeling continues to exist among the doctors, administrators and nurses. I think, however, that it is gradually being dissipated.

In 1948 the committee made its final report to the Trustees of the American Medical Association. Included in the report the committee recommended that there be two great classes of nurses. A. The professional nurse, and this group to be divided into collegiate nurses and hospital trained nurses. B. The trained practical nurse.

The percentage of the various groups recommended with collegiate nurses 15 per cent, hospital trained nurses 25 per cent, trained practical nurses 60 per cent. The committee also recommended that the Hospital Trained Nursing courses be reduced to two years. The courses of the Trained Practical Nurse to be one year.

I think the greatest achievement which came as the result of the study was the ability and willingness of representatives of the three groups involved to sit in the same room and around a conference table and calmly and dispassionately discuss the problems common to all.

Prior to the appointment of the American Medical Association Committee, Dr. Hugo Hullerman of the American Hospital Association, had recommended the formation of a committee of the three groups to study the problems common to all. An invitation to join this group came to the American Medical Association while the study was going on. The members of the committee were unwilling to affiliate with this group until the study was completed. The American Medical Association became affiliated with the Commission in 1948.

In 1948 the new Commission for the Improvement of the Care of the Patient was formed with six representatives from each organization on the Commission. Rules for operation were written and adopted—officers elected and the organization became a going concern.

The progress, as was to be expected, was slow in the formative years. Now with the ball well rolling, the organization is one of the very hard working organizations in the healing arts in this country. The Commission meets twice yearly. The attendance has been excellent—the discussions and debates stimulating.

The problems brought before the Commission are many and varied. In the beginning, they were the problems chiefly related to nursing. Now they cover

problems of administration—medical care, interns, the problems of the pathologist, radiologist, anesthesiologist.

Several States have now formed State Committees with representatives of the three groups meeting to discuss the problems common to all on the State level.

Very few medical men are familiar with the problems of the administrator. Budgetary problems are the common headache of the administrator. The difficult personnel problem is another. Personality conflicts another. Hours of work and allotment of work on different shifts or weekends or holidays another. Occasionally a controversy as to whether a problem is an administrative one or does it come within the province of the medical staff another.

Medical men in general are not familiar with the intricacies of the nursing problems. The nursing school problem is one of the difficult ones. Covering the hospital when the students are at class, required courses to conform to State laws, required hours for various courses, required nursing hours per patient day, nursing school budgetary problems, late notices to the nursing administrator that illness will prevent working that day or evening. The difficulty of getting the doctors to give lectures or bedside courses, the importance of getting the doctors to understand that these are absolutely necessary in the operation of an accepted nursing school.

And by the same token or measuring rod, administrators are unable to know or understand the problems of the medical staff. Suitable staff rooms for conferences are necessary. Adequate equipment for all reasonable procedures. Provision of a good library. Cooperation of the administrator in the teaching program of interns and residents. Cordial and cooperative people in the admitting offices.

And again by the same token the nursing leaders and nursing authorities should attempt to know the problems of the medical staff. Some of these problems are very burdensome and the responsibility is great. After all, the person who is chiefly responsible for the end result which his patient obtains is the physician. Has there been backbiting behind the scenes? Have the nursing leaders been carelessly evaluating the doctors to lay people? Have they been making relatives unhappy by criticizing the ability of the attending doctor?

Another delicate point is the position of the medical man who has courtesy privileges, but is not a member of the active staff. This might be due to

unwillingness on his part or nonacceptance of him by the staff. Every encouragement should be shown him by the administration and the nursing staff. The medical staff should see to it that he is invited to attend staff conferences so that his will be a continuing educational program. If the criticism comes from him, cordial relations can frequently be established by kindly actions of the administrator or nursing staff or members of the medical staff. If the criticism comes from the administrator or the nursing staff or the medical staff, he becomes a better doctor by attendance at staff conferences and by being familiarized with the problems of the administrator or the nursing staff.

I feel that where disagreements come up or exist in hospitals between the three groups that these are due to a lack of understanding of one group, of the problems of the other.

I am sure that a hospital Committee for the Improvement of the Care of the Patient would help a great deal in understanding and, yes, in solving these problems. We are all of us altogether too prone to be too critical of the other fellows shortcomings when we do not know them or understand them. It would seem to me that we will not be doing our full duty to the patient until we have set up in each hospital such a committee, bringing this advancement, and I feel it is a real advancement, directly to the patient. I urge you at this conference to seriously consider it and I hope that you will recommend it.

This hospital committee made up of representatives of the three groups would go far to aid in the solution of all of these problems. I would recommend also that the representatives be top flight people from each division.

One of the great problems confronting the American people today is the cost of hospital care. At the turn of the century and as late as the beginning of the second decade of this century, the cost to the patient in a ward was one dollar a day, a semi-private ward, one dollar and a half a day, a private room, two dollars a day. What a sad awakening one has when he receives his hospital bill today? A two weeks stay in a private room for a surgical patient will cost about five hundred dollars.

We glibly state that the patient now is more quickly ambulated and is discharged in about eight days where before he was in the hospital about fourteen days. Obviously this is not the whole answer. Heretofore, it was the common practice of the hos-

pital to furnish all but the most unusual and most expensive medications without charge. There was only limited use of x-rays. Laboratory work was limited and usually insignificant. Anesthesia administered by an untrained doctor or nurse. Drop ether and chloroform were about the only anesthetics used. All of this has been changed and necessarily so.

Are we as physicians depending too much on instruments of precision? Are we depending too much on the use of x-rays in chest examinations instead of the careful use of the stethoscope? Are we asking young laboratory technicians to make our diagnoses for us? Are we placing too great reliance on intricate laboratory tests when a careful history and physical examination would give us a more reliable answer? Are we placing too great stress on basal metabolic readings when a careful history of weight gain or loss, heart rate, blood pressure readings, hair distribution, bodily stature would give us a more reliable answer? Are we leaning too heavily on electrocardiographic tracings when a careful history and physical examination would tell us more? These are some of the questions we must ask ourselves and answer if we are to contribute to the reduction in the cost of efficient hospital care.

How many of us as doctors are familiar with the cost of the antibiotics, sulfa drug, cortisone, adrenal cortical trophic hormone? Have we been using these preparations carelessly or without indication? Have we been using two antibiotics that might have antagonistic effect? Again, these also are some of the questions which we must ask ourselves and answer if we are to help solve this problem.

How many of us are familiar with the cost of anesthesia, blood and blood derivatives, intravenous fluids, physiotherapy, basal metabolic readings, electrocardiograms, x-rays?

How many of our patients are being kept in private rooms in a general hospital when they would do as well or perhaps even better in a convalescent home if they are faced with long term illnesses at great cost to the patient and the hospital?

In the past each department has felt that their department was their own, was a separate department and was not the concern of the others. Now we have come to know that all are definitely inter-related and the work of each department must be coordinated with the others if we are to give our patients efficient and economical care.

For a long time I have felt that a hospital operating too far out of the red was defeating the purposes for which it was intended. When great profits are shown, that profit comes from blood. God did not intend that. At the same time I don't think it was intended that waste or carelessness should be permitted wherein great losses would be shown.

The dangers of socialism and communism are always before us. Both begin where there is want and are thrown out as sops to a suffering people. Both are grasped for, as a drowning man grasps for a straw, little realizing the price he eventually pays. The socialist and communist uses the cost of medical and hospital care as one of the great reasons for the adoption of this abominable philosophy.

We must find ways and means to see that our patients are given efficient medical and hospital care and that the cost is kept at a reasonable amount. If the present procedures continue, the cost of medical and hospital care will continue to increase and the law of diminishing returns will take command.

I feel that all of these problems and differences can be solved and answered by the generous cooperation of administration, nursing, and medical staff. This cooperation can be accomplished, I am sure, by the formation of a Committee for the Improvement of the Care of the Patient in each hospital. It is not a

new idea, but is a practical way of helping to solve these problems. With a Joint National Commission for the Improvement of the Care of the Patient functioning on the national level and with committees on the State level, it naturally follows that the proper place for implementation is on the hospital level.

I would further recommend that this committee meet monthly or bimonthly and that all of the problems of major or minor importance be reviewed and recommendations made for their solution.

This committee should be made up of top flight people. The seniors and leaders in each department should participate. In this way, policy making people could speak for their divisions.

We could in this way, and probably better than in any other way, familiarize all with the problems of each toward the end of providing the best medical care for all the people.

Finally we should keep before us, always, this fact, that when a husband brings his wife to the hospital, a wife brings her husband to the hospital, a father and mother bring their child to the hospital, they are giving to us, for our care, the body of a loved one, life's most priceless possession. We must not fail them.

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EDITORIALS

Tom Murdock

Like every other profession, medicine has its stalwarts. Tom Murdock was one of these. Devoted to his family, to his patients, and to organized medicine throughout the United States as well as in Connecticut, Tom Murdock lived a life of service to his fellowmen.

In this issue of the JOURNAL the editors have attempted to pay fitting tribute to Dr. Murdock. Included are testimonials from some of his friends together with many of his published papers. Not all of the latter could be included because of limitation of space. As one reads these expressions of appreciation from Tom's friends one is impressed with the fact that here was a man of high principles. To deviate from these was impossible; to be loyal to them was his duty. It also will become evident to the reader that Tom Murdock's interest in the unusual clinical problem progressed to an interest in the pertinent problems of medicine on a national scale. Medical expert testimony, prepayment medical care, diseases of middle life, and the pressing problem of the shortage of nurses he dealt with in addresses and committee reports. As chairman of a special committee of the American Medical Association to study the nursing problem he spent untold hours during his term as trustee in an endeavor to reach at least a partial solution of this complex situation. Another endeavor of his which was close to his heart was the National Foundation for Infantile Paralysis which he served in an official capacity for many years.

This issue of the JOURNAL is in no sense of the word a eulogy of the life of Thomas Patrick Murdock. It is Tom's valedictory for that is what he would wish it to represent. The words of the poet come to mind:

"The heights of great men reached and kept
 Were not attained by sudden flight,
 But they, while their companions slept,
 Were toiling upward in the night."

(The Ladder of St. Augustine—Longfellow)

Are There Practical Limits to Medical Care Insurance?

From time to time citizen groups, who apparently are dissatisfied with the progress which is being made by organizations such as CMS to meet the demands of the public for increased benefits under voluntary medical care programs, propose the establishment of new organizations to provide the benefits which they feel should be covered.

The latest proposal for such a program which "... would include preventive and diagnostic medicine, and the cost of the patients' visits to doctors and doctors' visits to the patients' home ..." comes from the Nineteenth Annual Convention of the Connecticut State CIO Council. Since such benefits, if they could be written on a sound underwriting basis, would ordinarily be provided by such a plan as CMS, it may be inferred that the proposal of a new organization to provide these benefits is an oblique criticism of CMS for not making such benefits available.

For some reason, which does not seem to be clear to those familiar with the entire picture of medical care, there has been a persistent demand by certain groups that the benefits noted above are an absolute necessity to an adequate medical care program. Regardless of the degree to which benefits are broadened and increased in other areas of medical care, such improvements of CMS contracts are considered negligible as long as they do not cover the particular services in question.

The underwriting basis for coverage of these particular benefits has been discussed so frequently and exhaustively by the most competent people in the insuring field that it should not be necessary to have the problem reviewed again. With the current proposal having been made, however, the basis for classifying most of these particular benefits as "impractical on an insurance basis" should be restated.

It is impractical to insure any "risk" when a sound analysis of its potential utilization approaches 100 per cent. Then it is no longer a "risk," it is a certainty. If it is a certainty, the cost of providing the benefit must obviously be based on the assumption of 100 per cent utilization of the benefit by those to whom it is available. Then, if the amount of the benefit is, for example, a certain type of examination at \$15, each member would have to pay at least \$15 more each year in order for the insuring corporation to have enough funds to pay the benefit to each member. We would also have to assume that the charge for the benefit would be the same whether it was paid by the individual or by an insurer. But, if it is paid by an insurer, the administration cost (of handling the claim, establishing the member's eligibility and making the payment, which is currently 10 per cent in CMS) must be added to the claim expense so it would probably cost each member \$16.50 in increased membership charges to have the examination which would only have cost him \$15 had he paid for it himself.

The only practical basis to write such a benefit would be to have some real assurance that even though all members paid toward it, only a relatively few would need to use it, but then we would be back on an insurable basis. No medical care insurance could be written to cover appendectomy if there was any reason to believe that every member would require such an operation during the year. Any "risk" whose anticipated utilization approaches certainty of occurrence is no longer insurance but "dollar-swapping." When administration costs must

be added to the "dollar-swapping" the patient-member pays more to be under a so-called "insurance" program than he would if he paid for his care himself.

Similarly, "risk" approaches "certainty" in the coverage of immunization inoculations, x-rays of the chest, routine blood examinations or urinalysis because everyone would like to use such benefits. It has been well said that "insuring" these types of professional services is like trying to insure the grocery bill which would hardly be a sound insurance business.

High Praise

William T. Salter came from Harvard to join the Yale Medical faculty as Head of the Department of Pharmacology in 1944 and in a brief period became one of the best known of the Yale faculty. He was in great demand as a speaker on the programs of both medical and lay organizations and in his simple forthright manner gave interesting information about newly developed drugs and their uses.

Dr. Salter was very active in affairs of the Society and largely through his genius in planning the valuable Committee on Foods, Drugs, Cosmetics and Devices, now known as the Connecticut Advisory Committee on Foods and Drugs, was organized. Through this Committee he pioneered in advocating a state law providing for the labeling of common household preparations that contain hazardous substances when accidentally ingested. He was always willing to appear before the legislature speaking soundly on behalf of good medical legislation and took part in the well remembered "paregoric" hearing.

The labeling of hazardous substances bill was not easy to pass but the General Assembly of 1957 did enact it into law; and, although Dr. Salter died in 1952, he was well remembered in the Capitol and the House and Senate on May 16 of this year passed a Joint Resolution of Tribute and Respect to him.

It was resolved: "Whereas, the late Dr. William Thomas Salter, who prior to his death in 1952, had served society and mankind, first as Assistant Professor of Medicine at the Harvard Medical School until 1941 and thereafter as Professor and Chairman of the Department of Pharmacology at the Yale School of Medicine, and

"Whereas, throughout his medical career, as student, physician and teacher he dedicated his strength and endeavors to the advancement of medical

knowledge and the alleviation of human suffering, and

"Whereas, his latter years were filled with an ambition to see enacted some form of legislation that would require proper labeling of packaged commodities containing dangerous or poisonous ingredients, in order that, when they might be improperly used or ingested by adults or children, the attending physicians would know immediately from the label what treatment to employ, and

"Whereas, Dr. Salter tragically did not live to see the fruition of his efforts, yet his leadership, determination and idealism inspired others to carry on the battle which resulted in the 'Labeling Bill' now enacted into law.

"Now, Therefore, Be it Resolved, that the General Assembly of Connecticut does hereby humbly express its profound respects to the memory of Dr. Salter, now that one of his lifetime objectives has belatedly come to successful fruition." This bestowed upon him the highest public tribute.

Hopkins Revises Medical Curriculum

On the heels of the announcement of the changes in the curriculum at Harvard Medical School comes the information from Johns Hopkins University School of Medicine that it is revising its curriculum so that specially selected students may save two years in their training and all students may save one year. A total of ten million dollars has been received from foundations, the U. S. Public Health Service, and private sources to finance the plan. This money will provide for a new basic science building at the medical school and salaries for additional faculty members.

The objectives of the new program as stated are:

1. To shorten the formal education of physicians without sacrificing quality of training.
2. To overcome the barrier between the liberal arts and medical sciences by enabling students in medical school to continue studies in the humanities and social sciences.
3. To encourage more students to enter careers in the basic sciences of medicine—such as physiology, anatomy, and pharmacology—where the greatest shortages of teachers and research workers now exist.

Selected candidates of adequate "motivation and maturity" will be permitted to enter medical school as full graduate students after only two years of college, while continuing their college education. Other students may enter after three years of college, and still others after the complete four years of college.

Those who are accepted after two years of college will take a five-year course in medical school. They will continue studies in the liberal arts during the first three years of medical school, at the end of which they will receive a bachelor of arts degree.

Students accepted after three or four years of college will begin medical school with the second year of the five-year program.

For all students the last year of medical school will be combined with the first year of internship in the Johns Hopkins Hospital, where each student will go through the major clinical services in turn, performing the duties now done by interns.

In addition to the usual 24 hour responsibility for patients, the student will be given a two months' elective period for special work in basic science or additional clinical training in any one of the various departments of the hospital. He will pay tuition but will receive board and lodging, or their equivalent, in return for services to patients.

At the time of graduation each student will have completed not only the required work in medical school but also a year of hospital internship.

While the years of medical training are cut, the actual period of training is shortened relatively little. In certain respects it will be more intensive than at present, for the academic year will be increased from the present 32 weeks to 40 weeks, and in the fifth year the training will cover 50 weeks.

The combined resources of the faculties of medicine, hygiene, and philosophy will become more widely available to graduate students in the basic medical sciences.

Johns Hopkins believes under the above program it can train more qualified teachers and investigators in special fields, that the free time allotted students will enable them to engage in more research, and that by shortening the total time of medical education the cost will be reduced and more time will be allowed for optimal postgraduate training in hospital residencies.

THE PRESIDENT'S PAGE

A subcommittee of your council headed by Dr. Gibson was appointed to study the purposes and operation of the various committees of the society and in an early report they tentatively recommended the discontinuance of the committee on the improvement of patient care. This suggestion was later withdrawn because Dr. Murdock who had long been interested in the project asked that the committee be continued. This was done, and the committee was reappointed.

This committee represents us on the Connecticut Joint Commission for Improvement of Care of the Patient, which also includes representatives from the Connecticut Hospital Association, the Connecticut State Nurses Association, the Connecticut League for Nursing and the Connecticut Public Health Association.

A meeting of the Commission was held on May 16 and there was considerable discussion of the costs of nursing programs and the nursing shortage: the latter subject one of vital interest to all physicians.

In March, 1956, the Connecticut Public Expenditure Council completed a two year survey of post-secondary school education in Connecticut at the request of former governor John D. Lodge. The questions it attempted to answer were "1. Who should go beyond the secondary school? 2. Who should provide higher education? 3. Who should pay for higher education?" In April, 1956, President Eisenhower appointed a committee on education beyond high school, with a broad mandate to alert the American people to the critical problem in post-high school education. The study is being implemented locally by the Connecticut Council on Higher Education. Generally, all post-secondary schools are concerned about the increased birth rate during the following World War II, which is expected to double the candidates for post-secondary education within the next fifteen years. The crest of this crop of "war babies" has now reached the junior high schools and within a very few years will be ready for higher education.

If schools of nursing are to train this new supply of student nurses, they must plan the resources which will be needed and anticipate the sources of funds to pay for them. Currently, much of the net cost of nursing education in hospital diploma programs is being absorbed by the sick patient. While this is essential at the present time, hospitals are committed to finding ways to relieve this burden from the sick patient and put it upon the community served, and a subcommittee of the Commission for the purpose of developing the costs of nursing education in Connecticut hospital diploma programs was appointed.

Regarding the nursing shortage, reference was made to a report just released by the National League for Nursing which predicts that nursing schools face an unprecedented expansion during the next fifteen years if the ratio of nurses to population is to be maintained and especially so if more students are to be prepared to meet the heavy demands for nursing service.

The National League for Nursing research staff has developed a method with which to predict future personnel and educational needs in nursing during the course of this study, and has urged State planning groups, such as this Commission, to apply the study to their own areas with the help of the National League for Nursing. The Commission voted to have the same subcommittee mentioned above work with the research staff of the National League for Nursing in projecting future needs for nursing service in the State of Connecticut.

The successful forwarding of these projects will be a big step in the improvement of patient care and in the fulfillment of Dr. Murdock's wishes.

W. Bradford Walker, M.D.

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COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

John H. Bunstead, New Haven (1959)
 John D. Booth, Danbury (1960)
 Carl E. Johnson, New Haven (1961)
 C. Louis Fincke, Stamford (1962)
 Louis P. Hastings, Hartford (1963)

COMMITTEE ON PUBLIC HEALTH

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 Noah Barysh, New Milford
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 Clarence W. Harwood, Middletown
 H. Patterson Harris, Jr., Fairfield
 Louis P. Hastings, Hartford
 William S. Maurer, Willimantic
 Leonard Parente, Hamden
 Marjorie A. Purnell, Rockville
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 J. Harold Root, Waterbury
 Arthur A. Tower, Meriden
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 William A. Wilson, Hartford
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COMMITTEE ON STATE LEGISLATION

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 Fairfield—John G. Murray, Greenwich
 Litchfield—Winfield E. Wight, Thomaston
 Middlesex—Asher L. Baker, Portland
 New Haven—Luca E. H. Celentano, New Haven
 New London—Edmund L. Douglass, Groton
 Tolland—Alfred Schiavetti, Stafford Springs
 Windham—Brae Rafferty, Willimantic

PROGRAM COMMITTEE

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 William J. Lahey, Hartford
 David T. Monahan, Bridgeport

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 Harold A. Bergendahl, Norwich
 E. Tremain Bradley, South Norwalk
 James C. Caniff, Torrington
 Amos E. Friend, Manchester
 Ralph L. Gilman, Storrs
 John L. Phiffer, Rockville
 James H. Root, Jr., Waterbury
 William A. Richardson, Noroton, Associate Member

CANCER COORDINATING COMMITTEE

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 Gerald M. Chartier, Danielson
 Joseph A. Chiota, Bridgeport
 Armano W. Ciccarelli, Bristol
 Tibor DeCholnoky, Greenwich
 Malcolm M. Ellison, New London
 William A. Geer, Bridgeport
 Lane Giddings, Manchester
 Mark A. Hayes, New Haven
 Isaac Horowitz, Bridgeport
 Perry T. Hough, Hartford
 Edward H. Kirschbaum, Waterbury
 William Mendelsohn, New Haven
 Norman K. Mottet, Derby
 Lincoln Oppen, Torrington
 Edward J. Ottenheimer, Willimantic
 Gioacchino Parrella, Milford
 John G. Raymer, Norwich
 Joseph A. Reynolds, Waterbury
 J. Forbes Rogers, Stamford
 Paul D. Rosahn, New Britain
 Isadore Rothstein, Hartford
 Alfred T. St. James, Wallingford
 Louis G. Simon, South Norwalk
 James T. Smith, Winsted
 William M. Stahl, Danbury
 William F. Stankard, Stamford
 John E. Thayer, Hartford
 Vincent J. Vinci, Middletown
 Wayne P. Whitcomb, New Haven

EXECUTIVE COMMITTEE—CANCER COORDINATING COMMITTEE

Allan J. Ryan, Meriden, *Chairman*
 Malcolm M. Ellison, New London
 William A. Geer, Bridgeport
 Mathew H. Griswold, Hartford
 Mark A. Hayes, New Haven
 Perry T. Hough, Hartford
 William Mendelsohn, New Haven
 Edward J. Ottenheimer, Willimantic
 Vincent J. Vinci, Middletown

COMMITTEE ON MENTAL HEALTH

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 John A. Atchley, Lakeville
 Stanley J. Alexander, Middletown
 Francis J. Braceland, Hartford
 Charles W. Culotta, New Haven
 Jean G. deChabert-Ostland, Hartford
 Franklin S. DuBois, New Canaan
 John E. Morrison, Norwich

COMMITTEE ON THIRD PARTY PAYMENTS

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 Donald G. Arnault, Middletown
 Michael J. Conroy, Meriden
 Frank H. D'Andrea, Stamford
 Benjamin V. White, Hartford

COMMITTEE ON EYE CARE

Clement C. Clarke, New Haven, *Chairman*
 Max Alpert, Bridgeport
 Morton Arnold, Willimantic
 Alfred L. Burgdorf, Hartford
 Merrill Grayson, New London
 Louis D. Harris, Hartford
 Joseph L. Hetzel, Waterbury
 Norbert W. Humpage, Torrington
 John F. Kilgus, Litchfield
 J. Myles O'Brien, Bridgeport
 Leonard Parente, Hamden
 John P. Simses, Bridgeport
 Arthur C. Unsworth, Hartford
 Frederick A. Wies, New Haven

Committees Appointed by the Council Without
 Election by the House of Delegates

COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

N. William Wawro, Hartford, *Chairman*
 Howard S. Colwell, New Haven
 Gregory K. Dwyer, Norwalk
 Daniel Hardenbergh, Bridgeport
 Edward Nichols, Hartford

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

Benjamin Katzin, Torrington, *Chairman*
 Bradford S. Colwell, New Haven
 Walter J. Keefe, Hartford
 Fritz M. Meyer, Bridgeport
 Henry J. Messinger, Fairfield

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Winfield O. Kelley, Norwich, *Chairman*
 Ralph T. Ogden, Hartford
 Oliver L. Stringfield, Stamford

COMMITTEE ON NATIONAL LEGISLATION

James S. Missett, Hartford, *Chairman*
 William B. A. Bentley, Waterbury
 Frank H. Couch, Cromwell
 Joseph A. Fiorito, New Haven
 W. Zeph Lane, Darien
 Charles T. Schechtman, New Britain
 Chairman, Committee on State Legislation
 Executive Secretary

COMMITTEE ON STATE BLOOD BANK

John E. Thayer, Hartford, *Chairman*
 Roy N. Barnett, Norwalk
 Henry N. Blansfield, Danbury
 Joseph O. Collins, Waterbury
 Theodore S. Evans, New Haven
 Frederick B. Hartman, New London
 C. Henry Huvelle, Torrington
 Rolf E. Katzenstein, Meriden
 Ralph E. Kendall, Hartford
 Christie E. McLeod, Middletown
 Sawyer E. Medbury, Willimantic
 Morris P. Pitcock, Bridgeport
 Paul D. Rosahn, New Britain
 Clair Rankin, Hartford
 Victor G. H. Wallace, Hartford
 Levin Waters, New Haven
 Ira V. Hiscock, New Haven, Associate Member

COMMITTEE ON MEDICAL CARE OF VETERANS

George A. Buckhout, Bridgeport, *Chairman*
 Francis D. T. Bowen, Hartford
 Joseph Bruno, New Haven
 Francis J. Kalamán, Norwalk
 Andrew P. Owens, Bridgeport
 Samuel B. Rentsch, Derby
 Roy V. Sanderson, Winsted
 Benjamin M. Shenker, Middletown

COMMITTEE ON RURAL MEDICAL SERVICE

Gaert S. Gudernatch, Sharon, *Chairman*
 Ludmil A. Chorkowski, Kensington
 Norman H. Gardner, East Hampton
 James H. Inkster, Ridgefield
 Mervyn H. Little, Willimantic
 Enos J. O'Connell, Unionville
 William H. Pomeroy, Poquonnock
 William H. Upson, Suffield

ADVISORY COMMITTEE TO THE STATE BOARD OF EXAMINERS FOR NURSING

Joseph A. Fiorito, New Haven
 Frederick W. Goodrich, Jr., New London
 W. Holbrook Lowell, Jr., Hartford

REPRESENTATIVES TO THE NEW ENGLAND POSTGRADUATE
ASSEMBLY

William J. Lahey, Hartford
Stanley B. Weld, Hartford

DELEGATES TO THE COUNCIL OF NEW ENGLAND STATE MEDICAL
SOCIETIES

Cole B. Gibson, Meriden
William H. Horton, Windsor
Oliver L. Stringfield, Stamford

COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Carl E. Johnson, New Haven, *Chairman*
Eric H. Blank, New London
C. Lee Buxton, New Haven
Lewis P. James, Hartford
David M. Little, Jr., Hartford
Bernard F. Mann, Jr., New Haven
Norman C. Margolius, Waterbury
Donald J. McCrann, Hartford
Hugh K. Miller, Stamford
Jessie E. Parkinson, Wethersfield
Charles H. Peckham, Manchester
A. Locke Robertson, Torrington
W. Leslie Smith, Hartford
Hoyt C. Taylor, Meriden
Archibald W. Thomson, Jr., Middletown
Stanley B. Weld, Hartford

ADVISORY COMMITTEE TO THE PUBLIC WELFARE DEPARTMENT

Edwin R. Connors, Bridgeport, *Chairman*
Ettore F. Carniglia, Hartford
Mark A. Gildea, Bridgeport
Maxwell Lear, New Haven
Donald R. Morrison, Hartford
Leonard Parente, Hamden
J. Harold Root, Waterbury
Edwin F. Trautman, Trumbull
William H. Upson, Suffield
Harold D. VonGlahn, Old Lyme

DELEGATES TO CONNECTICUT NUTRITION COUNCIL

Max Caplan, Meriden
Robert R. Levin, Hartford

REPRESENTATIVE—CONNECTICUT ADVISORY COMMITTEE ON
FOODS AND DRUGS

Hugh L. Dwyer, New Haven

CONFERENCE COMMITTEE FOR THE IMPROVEMENT OF THE CARE
OF THE PATIENT

Herbert D. Lewis, New Haven
D. Dillon Reidy, Hartford
J. Forbes Rogers, Stamford
Representatives from Connecticut State Nurses'
Association
Representatives from Connecticut Public Health
Association
Representatives from Connecticut Hospital Association
Representatives from League of Nursing

CONFERENCE COMMITTEE WITH CONNECTICUT STATE DENTAL
ASSOCIATION

Brae Rafferty, Willimantic, *Chairman*
David J. Cohen, Meriden
Cornelius S. Conklin, Bridgeport
Camille H. Huvelle, Torrington
Edward T. Wakeman, New Haven

COMMITTEE ON BUILDING MANAGEMENT

Carl E. Johnson, New Haven, *Chairman*
Stanley B. Weld, Hartford
The President of the Society

COMMITTEE TO STUDY PERINATAL MORBIDITY AND MORTALITY

Roswell D. Johnson, New Britain, *Chairman*
William K. Bannister, Hartford
Ronald S. Beckett, Hartford
Martha L. Clifford, Hartford
David J. Cohen, Meriden
Joseph A. Fiorito, New Haven
Robert L. Fisher, Sharon
Louis Guss, Norwich
Winston C. Hainsworth, Willimantic
C. Stanley Hinchins, New Haven
Charles A. Murphy, Stamford
Charles H. Peckham, Manchester
Andrew F. Turano, Middletown

REPRESENTATIVES OF CONNECTICUT HEALTH LEAGUE

Sue T. Gould, Old Greenwich
Clement F. Batelli, New Haven
S. Allison Rose, Stamford

CONFERENCE COMMITTEE WITH STATE BAR ASSOCIATION

Thomas M. Feeney, Hartford, *Chairman*
John D. Booth, Danbury
Oliver L. Stringfield, Stamford

CONNECTICUT COMMITTEE ON THE AMERICAN MEDICAL
EDUCATION FOUNDATION (AMEF)

William G. H. Dobbs, Torrington, *Chairman*
Fairfield—
Hartford—Charles E. Jacobson, Jr., Manchester
Litchfield—G. Robert Downie, Winsted
Middlesex—Louis O. LaBella, Middletown
New Haven—Orvan W. Hess, New Haven
New London—Paul J. Gerity, New London
Tolland—Marjorie A. Purnell, Rockville
Windham—Mervyn H. Little, Willimantic

COMMITTEE ON ACCIDENT PREVENTION

Louis Spekter, Hartford, *Chairman*
Harold A. Bergendahl, Norwich
Alfred L. Burgdorf, Hartford
Clement C. Clarke, New Haven
Gaert S. Gudernatch, Sharon
John F. Kilgus, Hartford
Bernhard A. Rogowski, New Haven
William M. Stahl, Jr., Danbury
Oliver L. Stringfield, Stamford

Duties of the Committees

Standing Committees

COMMITTEE ON ARRANGEMENTS

Article X, Section 3, Par. 1 of the By-Laws of the Society provides:

The Committee on Arrangements shall be appointed by the component county association with which the Annual Session of the Society is to be held. It shall provide suitable accommodations for the meeting place of the Society, and of the Special Sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program. The report of the Committee to Survey the Annual Meeting adopted by the House of Delegates on May 1, 1951 recommended that the chairman and one other member of the Committee on Arrangements, for the meeting in the year immediately preceding, serve with the Committee on Arrangements from the association in the county where the annual meeting is to be held. It was further recommended by the Committee to Survey the Annual Meeting, and adopted, that the Local Committee on Arrangements should be responsible for the arrangement of the program for the annual dinner of the Society.

COMMITTEE ON POSTGRADUATE EDUCATION

Article X, Section 3, Par. 2 of the By-Laws of the Society provides:

The Nominating Committee shall appoint to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purpose of the Committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society, and to cooperate with University and other agencies within the state for the extension of postgraduate education of physicians.

EDITORIAL BOARD OF THE JOURNAL

Article X, Section 3, Par. 3 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL, consisting of not more than fifteen members. One of these shall be nominated as the Managing Editor of the JOURNAL and he shall be a member of the Council also. One other member of the Board shall be nominated as Literary Editor of the JOURNAL and he shall serve as Chairman of the Editorial Board. The Literary Editor, with the active participation and advice of other members of the Board, shall be responsible for the acceptance or rejection of manuscripts for publication and for their literary quality. He shall not be concerned with the business or financial aspects of the JOURNAL, which shall be the responsibility of the Managing Editor. The remaining members of the Editorial Board shall be selected so far as feasible, to represent the major division of medicine, surgery, pediatrics, obstetrics and psychiatry and consideration shall be given to representation from the geographic areas of the state. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privi-

leges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

COMMITTEE ON HOSPITALS

Article X, Section 3, Par. 4 of the By-Laws of the Society provides:

The Nominating Committee shall nominate annually to the House of Delegates, a Committee on Hospitals to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue the continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

COMMITTEE ON INDUSTRIAL HEALTH

Article X, Section 3, Par. 5 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the chairman thereof. The function of this Committee shall be to inquire into health in industry for the purpose of making the information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

Article X, Section 3, Par. 6 of the By-Laws of the Society provides:

At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the

Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

PROGRAM COMMITTEE

Article X, Section 3, Par. 7 of the By-Laws of the Society provides:

The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange a scientific program for the meetings of the Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceeding the date of the meeting.

COMMITTEE ON PUBLIC HEALTH

Article X, Section 3, Par. 8 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually one member from each component county association and such additional members as it may determine, not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration, desirable legal enactments to promote public health within the State.

COMMITTEE ON STATE LEGISLATION

Article X, Section 3, Par. 9 of the By-Laws of the Society provides:

Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation. In addition to these eight members, the Committee shall include the Delegates to the American Medical Association and the Executive Secretary who shall serve as the executive officer of the Committee. The Chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed state legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this State, appropriate legislation for improving medical care and the public health within the state, advise the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the state legislative field.

COMMITTEE ON PUBLIC RELATIONS

Article X, Section 3, Par. 10 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and cooperate with other committees of the Society in a program of public relations.

CANCER COORDINATING COMMITTEE

Article X, Section 3, Par. 11 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee. The membership of this Committee shall include a chairman, one member from the cancer committee of each general hospital in Connecticut, and shall at all times include the President of the Connecticut Cancer Society and a representative of the State Department of Health. This Committee shall be governed by an Executive Committee designated by the Council, which shall include the chairman, President of the Connecticut Cancer Society, representative of the State Department of Health, and six members selected from the other membership of the Committee. The purpose of this Committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut, to aid and encourage the establishment and maintenance of high professional standards in the cancer clinics of the general hospitals, and to organize and promote professional education regarding cancer in Connecticut.

COMMITTEE ON PROFESSIONAL RELATIONS

Article X, Section 3, Par. 12 of the By-Laws of the Society provides:

At its semi-annual meeting in 1950, each component county association shall elect a past-president of the Association to serve on a State Committee on Professional Relations. The members so elected from the associations in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951, at which time the Hartford, New London, Windham and Middlesex county associations shall elect a past-president to serve on the State Committee on Professional Relations for a period of two years, and such election shall be biannually thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield and Tolland shall serve until the annual meeting of these county associations in 1952, at which time the New Haven, Fairfield, Litchfield and Tolland county associations shall elect a past-president to serve on the State Committee on Professional Relations for a period of two years and such election shall be held bi-annually thereafter.

No member shall be elected to serve two consecutive

terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except by invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional mal-practice or negligence. The purposes of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society Secretary, either from the public or other physicians, they will be referred at once to the Secretary of the county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with the county association. If in the judgment of the appropriate Committee in the county association, the complaint should be heard by the State Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee representing the county association to which a physician against whom charges have been brought belongs shall not vote on the final conclusion reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arriving at a decision, shall notify the physician against whom charges have been brought of its findings and disciplinary action to be taken, and at the same time, file a resume of its findings and action with the secretary of the County Association to which the physician belongs and with the Council of the State Medical Society. A member disciplined by the action of the Committee shall have the right of appeal to the Council before the expiration of fifteen days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

COMMITTEE ON MENTAL HEALTH

Article X, Section 3, Par. 13 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. The Committee shall be continuously informed concerning the provisions for the care of the mentally ill in the state and those addicted to the use of habit-forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this state so afflicted.

COMMITTEE ON THIRD PARTY PAYMENTS

Article X, Section 3, Par. 14 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Third Party Payments to consist of five members and nominate the chairman thereof. The function of this Committee shall be to study existing and projected systems providing payment for physicians' services by any public, private, or cooperative agency, and to advise the Society concerning them. In its operations, the Committee shall confer with representatives of such agencies and other committees of the Society having interest and responsibility in specific phases of medical care that involve payment of physicians by third party agencies.

COMMITTEE ON EYE CARE

Article X, Section 3, Par. 15 of the By-Laws of the Society provides:

The Nominating Committee shall nominate annually to the House of Delegates a Committee on Eye Care and nominate the chairman thereof. The membership of this committee shall be not more than fifteen members and shall include at least four but not more than seven members of the Executive Committee of the Eye, Ear, Nose and Throat Section and shall include the advisors from the Society to the Public Relations Committee of the American Medical Association Section on Ophthalmology. The purpose of this committee shall be to coordinate and integrate the efforts of various agencies whose functions may include some phase of eye care, to cooperate with other committees of the Society in the eye care phases of their activities, and to cooperate with the AMA committees concerned with the promotion of eye care. The Committee shall develop and make available to members of the Society and all other persons interested in improving eye care, information on all phases of eye care. The Committee shall also, as occasion arises, recommend for the Society's consideration desirable legislative enactments to promote improvements in eye care within the state.

Committees Appointed by the Council

(Not requiring election by the House of Delegates)

COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

The purpose of this committee is to continue and strengthen the historic close relationship between the Connecticut State Medical Society and the Yale University School of Medicine and to further the effectiveness of undergraduate and graduate programs of medical education.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The purpose of this committee is to serve in an advisory capacity to the Woman's Auxiliary of the State Medical Society in matters of general policy, insofar as they relate to the program of the State Medical Society and upon request, to confer with the Auxiliary in the development of this program.

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

The purpose of this committee is to provide a continuing conference group between the Connecticut State Medical

Society and the Connecticut Pharmaceutical Association for the study and integration of the purposes and objectives of the common problems of the professions of medicine and pharmacy in Connecticut.

COMMITTEE ON NATIONAL LEGISLATION

The purpose of this committee is to be informed constantly concerning proposed national legislation relating to medical care and welfare. The committee shall advise the Council on details of proposed legislation in the fields of health and welfare and express its opinion, with appropriate approval, to Connecticut Representatives and Senators in the Congress of the United States. The Committee shall endeavor to keep members of the State Medical Society informed on trends and developments in national legislation that may be expected to affect medical service.

COMMITTEE ON STATEWIDE BLOOD BANK

The purpose of this committee is to promote the development of a statewide blood bank operating in the interests of the people and the medical profession. The committee is authorized, in the name of the Society, to cooperate with responsible agencies such as the American Red Cross, the State Department of Health, in prescribing professional policies of the operation of a blood bank.

COMMITTEE ON MEDICAL CARE OF VETERANS

The purpose of this committee is to cooperate with the Medical Section of the U. S. Veterans Administration and to represent the medical profession in Connecticut in all negotiations concerning the medical care of veterans, the payment for such care, and matters of general medical policy, and to serve as the Medical Advisory Committee to the Connecticut Veterans Home and Hospital.

COMMITTEE ON RURAL MEDICAL SERVICE

The purpose of this committee is to develop a program of medical service for the rural population of Connecticut in cooperation with the Council on Rural Medical Service of the AMA.

ADVISORY COMMITTEE TO THE STATE BOARD OF EXAMINERS FOR NURSING

The purpose of this committee is, upon request, to cooperate and advise with the State Board of Examiners for Nursing in matters of general policy.

COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

The purpose of this committee is to study maternal mortality and morbidity in Connecticut with the purpose of making their best contribution toward lowering the maternal and morbidity rate from these causes.

ADVISORY COMMITTEE TO THE PUBLIC WELFARE DEPARTMENT

This committee was appointed, at the request of the Commissioner of Public Welfare of the State of Connecticut, to advise with him and the Medical Director of the Public Welfare Commission in all matters concerning medical care and hospitalization and to endeavor to maintain cooperation between the commissioner of Welfare and the medical profession of the State.

CONFERENCE COMMITTEE FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT

This is a joint committee, consisting of representatives from the State Medical Society, the State Nurses' Association, and the State Hospital Association. Its purpose is to study problems of mutual interest to the medical, nursing and hospital administrative professions with a view to finding solutions to problems involving improvement of the care of hospital patients.

CONFERENCE COMMITTEE WITH THE CONNECTICUT STATE DENTAL ASSOCIATION

This committee is appointed to be the conference group with the State Dental Association and to discuss with that group problems of mutual interest to the two professions and bring the professions into closer relationship in all fields.

COMMITTEE ON BUILDING MANAGEMENT

The purpose of this committee is to supervise the operation of the Society's headquarters building, including all details of its financing.

COMMITTEE TO STUDY PERINATAL MORBIDITY AND MORTALITY

The purpose of this committee is to inquire into the causes of perinatal mortality in Connecticut with the object of making suggestions for the removal of the causes of perinatal mortality.

CONFERENCE COMMITTEE WITH THE CONNECTICUT BAR ASSOCIATION

The purpose of this committee is to confer from time to time with representatives of the Connecticut Bar Association on matters of mutual interest to the medical and legal profession.

AMERICAN MEDICAL EDUCATION FOUNDATION

The purpose of this committee is to supervise and direct the solicitation of funds from physicians in Connecticut for the American Medical Education Foundation.

COMMITTEE ON ACCIDENT PREVENTION

The purpose of this committee is to study the causes and methods of prevention of personal accidents in Connecticut and in cooperation with the Committee on Accident Prevention of the Connecticut Chapter of the American Academy of Pediatrics and similar committees from other organizations, to make recommendations to prevent accidental injuries among the people of the state.

MEDICARE COMMITTEE

The purposes of this committee are to: (1) cooperate with the Office for Dependents' Medical Care of the Department of Defense and Connecticut Medical Service in the operation of the Dependents' Medical Care Act (PL. 569, 84th Congress) in Connecticut, (2) supervise the medical professional phases of the plan in Connecticut, (3) determine appropriate fees for medical services not included in the Connecticut Schedule of Allowances, (4) determine matters of policy within the State jurisdiction, and (5) direct the plan coordinator in Connecticut.

NEWS FROM WASHINGTON

House Committee Approves New Machinery for Doctor Procurement

To replace the special doctor draft act that expired June 30, the House Armed Services Committee on May 8 approved an amendment to the regular draft act. It was drawn up by the committee staff and differs from the bill (HR6548) offered by Defense Department. The House passed this bill May 23. The bill would:

1. Authorize the special call-up of physicians, dentists, and allied specialists through age 35 if they have had educational deferments; they would be drafted as members of their professions, rather than by age groups, as is the case with other draft registrants.

2. Continue the National, State and Local Medical Advisory Committees to Selective Service System; in its bill Defense Department did not ask to have the committees continued, explaining that this was a Selective Service matter and Selective Service had not requested they be retained.

3. Continue several provisions that were in the special doctor draft act, but not in the department's bill, including: right of doctors to volunteer for and be commissioned at an early date, right of doctors to resign their commissions after 12 months or more of active duty, provision for use of alien physicians in the military services.

Congress Urged to Pass Jenkins-Keogh Retirement Program

Members of House and Senate are receiving "thousands of messages" urging enactment of the Jenkins-Keogh retirement legislation, according to Rep. Thomas Jenkins (R-Ohio), one of the sponsors. In a statement in the Congressional Record, Mr. Jenkins declares: "I am sure that practically all members have been receiving messages of some kind with reference to the Jenkins-Keogh bill. . . . As proof that it is a good bill, on yesterday I received 300 telegrams in favor of this bill, so it seems to be very popular. These telegrams were signed by doctors, lawyers and influential businessmen. I am advised that the membership of the House and Senate have received thousands of messages."

The legislation is being supported by the American Thrift Assembly for Ten Million Self-Employed, which is acting on behalf of the American Medical Association and a number of other national associations representing the self employed. Recently the Assembly asked its affiliates to urge their members to communicate with members of the House Ways and Means Committee, where the Jenkins-Keogh bill now is under consideration.

The bill would (a) allow the self employed to put up to 10 per cent of their income per year (maximum of \$5,000) into restricted annuity programs or insurance without paying income tax on the amount, (b) receive the money back in the form of pension payments, generally after age 65, and at that time pay income tax on it. Employees of corporations now have the same tax advantage, and (c) impose a tax penalty if the money were withdrawn from the fund prior to the stated retirement age.

House Committee Opposes Free Choice in Medicare

The powerful House Appropriations Committee has brought up a formidable Medicare problem: It has gone on record for curtailment of free choice of civilian medical and hospital services by dependents of military personnel. Specifically, the committee would deny civilian care to dependents unless military facilities and professional personnel in the area are shown to be inadequate to accommodate these supernumeraries. Under existing law and regulations, dependents may choose between military or Medicare (civilian) services. A clause authorizing SecDefense to withhold government paid civilian care from dependents in areas where adequate facilities of a uniformed service are available has not been invoked since Medicare program was launched last December.

Rep. Daniel J. Flood (D-Pennsylvania) was responsible for the committee recommendation to restrict freedom of choice. He was a member of subcommittee which interrogated Maj. Gens. Silas B. Hays and Paul I. Robinson on dependent care. Of course, any move by Defense Department to comply with this "suggestion" (with its or-else implication) that free choice be modified will arouse

opposition of organized medicine, dentistry and hospital elements.

Appropriations Committee's contention is that government will save money if bulk of dependent care is performed in military facilities. "Reports received by the Committee," said its report, "indicate that disruption of medical services available to civilians have occurred in some communities since inception of this (Medicare) program."

General Robinson, Medicare administrator, is asking the advisory committee to study recommendations he has made on problems confronting program and mail in their comments. Principal issues are as follows:

1. Difficulties over fee schedules, particularly involving definitions of medical and surgical services. Recommendation: That national specialty societies submit revised nomenclature for all items in their professional spheres.

2. Compensation of hospital residents for care given dependents, a question on which there is sharp division of opinion. Recommendation: That residents be disqualified for compensation, provided the hospital does not come out the loser.

3. Simplification of billing procedures. Recommendation: That in instances where a dependent receives care in a large clinic (30 or more full-time physicians), a single bill is permissible. At present, individual bills are required.

4. Liability of patient and government. General Robinson recommends regulatory changes to spare dependents from paying for second admission to hospital due to some complication (i.e., hemorrhage following tonsillectomy); to eliminate confusion over liability for payment of private duty nurses, and to provide for greater flexibility in matter of choice of hospital room accommodations.

One of biggest headaches has centered around provision of drugs, at Federal expense, for maternity patients. Pharmacists think doctors should not be allowed to supply these items (mainly nutritional supplements). Many doctors are dissatisfied with paperwork required in order to be reimbursed. However, no change in present policy was recommended.

New Doctor-Draft Passed; Briefs From Congress

In June the House passed, by voice vote, HR6548, the modified doctor draft plan which is pro-

posed to replace the stricter law which has been in force since September, 1950. Senate approval is virtually assured, perhaps without need of holding public hearings, since no opposition has been registered against HR6548.

Senate Appropriations Committee was scheduled to act during the month of June on Department of HEW budget for 1957-58. Very little divergencé from House-passed funds for Public Health Service, Food and Drug Administration and other HEW bureaus is anticipated.

Back at his House desk recently, after attendance at World Health Assembly in Geneva, was Rep. John E. Fogarty (D-Rhode Island), who shepherded the HEW budget through the House. Cited as "a champion of better health for the nation," Fogarty was inducted into Omicron Kappa Upsilon honorary dental society at Georgetown University. Also honored was Col. Joseph L. Bernier for his contributions to oral pathology.

Starting recently, expert testimony on radioactive fallout hazards was taken by a special subcommittee of Joint Committee on Atomic Energy. Rep. Chet Holifield (D-California) is chairman.

Blue Cross, Blue Shield and American Hospital Association issued a joint statement urging favorable action on the Holifield bill (HR7034) for Federal employees' contributory health insurance. But early consideration of this or any of the other similar bills is not indicated.

Research Building Grants Up for Consideration

Advisory council opening 3 day meeting here recently studied 148 applications for matching grants to build, improve or remodel research facilities in hospitals, professional schools, research foundations and other nonprofit institutions. The requests total \$34,035,265. No more than \$30 million will be available in next fiscal year for this program.

Federal Hospital Council, at its meeting next month, will pass on 24 applications for grants in support of research into administrative, logistic and other hospital problems. A maximum of \$1.2 million will be available for this assistance during coming fiscal year.

In Fewer Words

Atomic Energy Commission has awarded 29 more contracts for medical research projects, totaling

about \$750,000, with \$252,500 of this sum going to Dr. H. L. Friedell at Western Reserve to support radiobiology studies . . . recipients of April loans from Small Business Administration included a hospital and two convalescent homes. Dr. I. S. Ravdin, the noted Philadelphia surgeon whose influence on governmental medical affairs is considerable, defended Medicare payments to hospital residents in address he gave recently on program observing Wharton School's 75th anniversary. U. S. invitation accepted in Geneva, next year's World Health Assembly probably will be held in New York or San Francisco.

20 Medical Schools in Line for MENDS Program of Defense Department

Twenty additional medical schools have applied to participate in the medical education for national defense (MEND) program sponsored by the Defense Department. Under it, faculty members of participating schools are indoctrinated in military and disaster medicine through symposia and other means being developed by the armed services. Courses, in turn, are offered students. According to Assistant Defense Secretary Frank Berry, 10 schools will be picked from among the 20 early in June. This will bring to 45 the number of schools offering special courses.

At a press conference, Dr. Berry also noted a "sharp" decrease in the number of resignations from the medical branches of the armed services. He attributed this to the passage last year of the career incentive act, which provides for additional pay for doctors serving beyond two years and also gives them additional credit toward promotions and retirement. There are enough physicians now commissioned or committed to service to take care of the military's needs for the next fiscal year without having to draft any doctors, he said.

He also reported on the success of a Defense mutual aid program in which teams go to foreign countries to help troops of our allies improve their nutrition. Five surveys have been completed (Iran, Pakistan, Korea, Philippines and Turkey) and one was to start in Libya in June.

Senate Unit Votes \$25 Million Loan Authority for Hospitals

At the behest of the American Hospital Association, the Senate Banking and Currency Committee

on May 16 voted to earmark \$25 million of an increased loan authority under the Federal Housing Administration so hospitals can borrow money to build living quarters for student nurses and interns. The AHA originally had suggested \$150 million; a subcommittee trimmed this two thirds; and the full committee reduced it to \$25 million.

Under the proposed amendment to the housing act, hospitals with state approved educational programs for nurses and interns could borrow money at 2% per cent, with repayment over as much as 40 years. These types of loans have been available since 1950 for colleges but not for hospitals.

In its presentation to the committee, the AHA contended that the need for hospital nursing schools was of the greatest urgency. The amendments to a general housing bill which already has passed the House will be taken up within the next few weeks by the Senate. After that, the measure will have to go to House and Senate conference to work out differences.

U. S. Contribution to WHO Budget Drops to One-Third

Because Russia and three satellite countries are returning to active participation in the financing of the World Health Organization, the U. S. contribution for the current year will drop to one third, for the first time since WHO was organized. The information was received in Washington from the WHO assembly meeting in Geneva. Because there is no mechanism that permits a country to "resign" from WHO, two budgets were prepared for the years the Communist bloc did not participate. One included the assessments against those countries, and the U. S. contribution was based on this "fictitious" budget. When the U. S. then paid its share of the inflated budget, the total turned out to be a higher percentage of the smaller actual budget.

This year there will be only one budget—for \$10.7 million. Of this the U. S. will pay one third. The Communist countries—Russia, Albania, Bulgaria and Poland—will pay a total of \$1.5 million. At the request of the administration, Congress last year removed a \$3 million ceiling that had been placed on the U. S. contribution.

At the Geneva meeting, Rep. John E. Fogarty (D—Rhode Island) officially invited the WHO assembly—governing body of the organization—to hold its 1958 meeting, its tenth, in the United States. Congress last year had authorized the invitation.

AFL-CIO Sets Up Fund to Fight Foes in Medicine

Executive council of AFL-CIO has earmarked money, amount undisclosed, for a war chest to finance legal counsel, technical aid and public education in behalf of labor sponsored medical service plans. The gesture demonstrates labor's willingness to give greenback, as well as moral, support to direct medical service plans which are experiencing rough going in some cities. Association of Labor Health Administrators will administer the fund, to be used in "defense of the victims of any efforts on the part of medical power groups to destroy programs which endeavor to improve the quality and scope of pre-paid health services available to working people and their families."

AFL-CIO expressed concern over "an apparent concerted renewal of attacks upon such programs by monopolistic elements of organized medicine . . . in clear defiance of principles of law and ethics established by numerous court decisions."

Borden Research Awards

A total of 254 senior medical students have received \$500 Borden Undergraduate Research Awards in Medicine over the past 13 years. This is reported in a new Borden Company Foundation directory which, for the first time, lists all the college and university scholarship awards and prizes sponsored by the foundation.

The awards, at 26 schools, are for senior medical students whose research as undergraduates has been deemed to be the most meritorious in their class.

The basic purpose of the program is to furnish incentive for high scholastic attainment and to dramatize the importance of such attainment. The freshman awards, begun on an experimental basis in 1956, seek to recognize at the very beginning of the college career the importance of good scholarship.

Schools at which these medical awards are made are: University of California, University of Chicago, University of Cincinnati, Columbia University, Cornell University, Duke University, Harvard Medical School, University of Illinois, State University of Iowa, Johns Hopkins University, University of Michigan, University of Minnesota, New York University, Northwestern University, Ohio State University, University of Pennsylvania, University

of Rochester, Saint Louis University, Stanford University, University of Texas, Tulane University, Vanderbilt University, Washington University, Western Reserve University, University of Wisconsin, and Yale University.

In all instances the colleges select the award students and administer the grants.

Meetings Held in June at State Society Building

- June 10—Committee on Eye Care
- June 12—Committee to Study Maternal Mortality and Morbidity
- June 13—Committee on Public Health
Board of Directors, Connecticut Medical Service
- June 17—Woman's Auxiliary School of Education
- June 18—Medical Advisory Committee, Connecticut Cancer Society
Conference Committee with Connecticut State Dental Association
- June 19—Committee on State Blood Bank
Committee on Accident Prevention
Sub-Committee on School Health
- June 20—Council
- June 27—Committee on Public Relations

AMA Delegates Reaffirm Opposition to Social Security

The American Medical Association House of Delegates at its recent session in New York City rejected the resolutions from New York and Connecticut and reaffirmed its opposition to coverage for physicians under the OASI provisions of the Social Security Act. Connecticut also introduced a resolution calling for a nationwide referendum on the question. This was rejected and a recommendation adopted for a stepped-up informational program of education which will reach every member of the AMA, explaining the reasons underlying the position of the House of Delegates on this issue.

A complete report on actions of the House of Delegates will appear in the August issue of the JOURNAL.

YOUR MEDICAL PASSPORT FOR EMERGENCY CARE

If you should ever require emergency medical attention away from home, the attending physician could best care for you if certain information were instantly available.

The purpose of this card is to provide such information. It combines identity information with notations about physical conditions which might affect the manner of emergency treatment, such as allergies, drug sensitivities and others.

The card is intended to be filled out at the time of a physical examination. When you have your next examination, ask your doctor what entries he feels should be made on your card.

Connecticut State Medical Society

Emergency Medical Card

Name _____ Height _____
 Address _____ Weight _____
 _____ Hair _____
 (Nationality) (Religion) (Birth Date)
 (Social Security No.) (Signature) Eyes _____

OPEN

CONNECTICUT STATE MEDICAL SOCIETY
New Haven

When treating a stranger in an emergency, wouldn't on-the-spot information be helpful?

The Emergency Medical Card is designed to furnish information from the family physician about conditions which might affect emergency treatment, such as allergies, drug sensitivities, etc. It is especially useful for diabetics.

The card is intended for preparation following a regular physical examination. Medical information can be quickly noted on one side of the card, and the patient can fill in the other side.

This new card is really a message from one physician to another in time of emergency—a medical guardian for the many Americans who now travel away from their home communities more than ever before.

If you desire ten cards for test purposes, or would like to obtain a quantity of them at cost, use the coupon below.

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please send 10 Emergency Cards to:

Name

Address

Check enclosed for 100 cards: \$3.00 ☐

200 cards: \$5.00 ☐

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

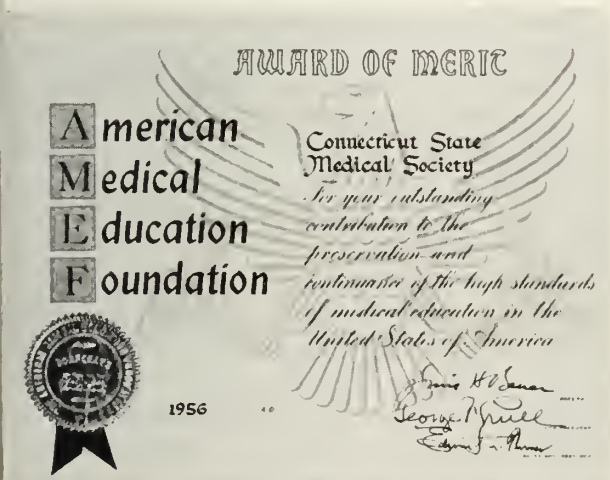
Harry C. Knight, Middletown
Chairman
Harold A. Bergendahl, Norwich
James C. Canniff, Torrington

E. Tremain Bradley, South Norwalk
Amos E. Friend, Manchester
John L. Phiffer, Rockville

Ralph L. Gilman, Storrs
James H. Root, Jr., Waterbury
William A. Richardson, Noroton
Associate Member

State Medical Society Receives Award of Merit for AMEF Activities

An award of merit for participation in the 1956 campaign of the American Medical Education Foundation was presented to the Connecticut State Medical Society at the June meeting of the American Medical Association's House of Delegates in New York City.



The award was one of 15 presented to state medical associations most active in AMEF activities. The 1956 campaign established a new national record in raising \$1,072,727 from 39,892 contributors to aid the nation's medical schools.

The campaign in Connecticut brought \$20,795 in contributions from 916 physicians, medical associations, and the Woman's Auxiliary to the State Medical Society. This result placed Connecticut in sixth place in the national AMEF campaign as to both total contributions and the number of contributors.

A recent report indicates that the 1957 campaign is far ahead of the 1956 and previous campaigns for the first five months of the year. The report indicates total contributions of \$4,426 from 192 contributors. All of the Connecticut activities this year are being

conducted as independent campaigns of the county medical associations with administrative assistance at state level when required. With some counties not fully active in the current campaign, results for the first five months are reported as follows: Hartford County, \$2,620 from 126 contributors; New Haven County, \$720 from 20 contributors; Fairfield County, \$520 from 14 contributors; Litchfield County, \$356 from 22 contributors; New London County, \$130 from 4 contributors; Middlesex County, \$45 from 4 contributors; and Tolland County, \$35 from 2 contributors.

William G. H. Dobbs, Torrington, is chairman of the Connecticut AMEF Committee and members are G. Robert Downie, Winsted; Paul J. Gerity, New London; Charles E. Jacobson, Jr., Manchester; Orvan W. Hess, New Haven; Louis O. LaBella, Middletown; Mervyn H. Little, Willimantic; and Marjorie A. Purnell, Vernon.

Educational Films Viewed by More Than One Thousand High School Students

Educational films portraying medical training and practice were viewed by more than 1,000 high school students in ten Connecticut communities during the past three months.

The films were produced by the American Medical Association. They are furnished upon request without charge to school and community groups through a New York film agency in cooperation with medical associations in northeastern states.

The report indicates the films were viewed by students in the following communities: Greenwich, Milford, Columbia, Bridgeport, Windsor, Waterbury, Woodmont, North Grosvenordale and Old Lyme.

The films were also shown to community and church organizations in Deep River, Bethany and Easton. Information concerning availability of the films may be obtained through the offices of the State Medical Society

Radio Stations to Be Honored for Health Programs

Eighty-seven radio stations will be honored by the American Medical Association this year for outstanding activity in broadcasting AMA health education radio transcriptions.

More than 260 radio stations throughout the United States and Alaska have qualified for this transcription since 1954. Many of the stations using the AMA electrical transcriptions are serviced directly from the Bureau of Health Education through county and state medical associations.

Services of the New Britain Medical Society Featured in Local Press

The services and activities of the New Britain Medical Society were recently featured in an article published in the *New Britain Herald*.

The article was one of a series prepared by the New Britain Council of Social Agencies and titled "Health Services Available in City." The article outlines the organization of the New Britain Medical Society, the Emergency Medical Call Plan and other community service programs sponsored by the organization. In an editorial note readers are encouraged to clip the article and retain it with others in the series as a handy health service directory.

Thirty Minute Health Education Telecast Produced by State Medical Society

A health education telecast on injuries and ailments of the upper and lower back was sponsored by the State Medical Society in cooperation with the Hartford County Medical Association June 15 from the studios of WHCT, Hartford, Channel 18.

Dr. Robert Walker and Dr. Vincent J. Turco, both of Hartford, were panelists for the 30 minute program and moderator was Robert Wakeley, director of Health Education for the Connecticut Division of the American Cancer Society.

The program was one in a series, "Accent on Living" produced by the Connecticut TV Committee for Health Education. The committee comprises representatives from the 15 leading statewide health organizations and the four major television stations. Programs in the series are presented each Saturday from 4:30 to 5:00 P. M.

USPHS Launches Nationwide Health Survey

A new National Health Survey was initiated in May by the U. S. Public Health Service, according to AMA's Council on Medical Service.

The council reports that a household interview survey is being conducted in 330 sampling areas throughout the country. Legislation enacted during the last session of Congress authorized the surgeon general of the USPHS to make surveys and special studies of the U. S. population to determine the extent of illness and disability and related information.

The council stated that the American Medical Association supported this legislation while cautioning that any survey in this area should be conducted in such a manner that all interested parties can agree substantially with its conclusions.

Facts to be collected include statistics on the number, age, sex, and other personal characteristics of persons suffering from diseases, injuries, or handicapping conditions; the length of time that these people have been prevented from carrying on their usual activities, and whether the conditions have had medical attention. The last survey of this nature was conducted 20 years ago.

The council also announced that the household interview phase of the survey is to be a continuing study for an indefinite period of time. Field work will be handled by the Bureau of the Census for the USPHS, following primary sampling units already established in counties, parts of counties, combinations of counties, or metropolitan areas. At least one sampling unit is located in every state.

A New Standard for Attendance at Staff Meetings

The Joint Commission on Accreditation of Hospitals has modified its requirement for active staff attendance under the standards for hospital accreditation. The old standard specified at least 75 per cent of active staff attendance at staff meetings. The new standard reads: "Active staff attendance shall average at each meeting at least 50 per cent of the active staff who are not excused by the Executive Committee for just cause. Each active staff member shall attend 50 per cent of the staff meetings unless excused by the Executive Committee for just cause."

FROM OUR EXCHANGES

During recent years the solitary pulmonary nodule has excited the interest of many medical men. Peabody *et al.* consider that the chance of malignancy in any solitary, noncalcified nodule is high, approximating 50 per cent in older patients and almost 30 per cent in patients 30 to 39 years of age (*Med. Ann. Dist. Col.*, XXVI:1, pp. 1-7). There exists no reliable clinical, laboratory or radiographic means, unless it be the presence of calcification, for differentiating between the malignant and benign nodule. In the authors' opinion thoracotomy is mandatory. In those with bronchial carcinoma the absence of symptoms and promptness of operation are likely to determine the possibility of cure. It is stated in the article that a careful histologic study of the so-called "tuberculoma" will show that the majority are fungal rather tuberculous in origin.

* * * *

Under the title "Viruses, Man's Variable Associates" Wilbur speculates on the roll of the viruses in the production of disease in the human race (*Jour. Arkansas Med. Soc.*, 53:11, pp. 315-322). The intimate association of viruses with genetic material in the host cells increases the significance of the viruses. This intimate association may be important in both heredity and tumor formation. The development of the previous phase and the ability to mutate provides an explanation for many behaviour problems associated with viruses. Knowledge of the fact that the active metabolic phase of the life cycle of a virus is within the host cell is an adequate explanation for the usual failure of antibiotics in virus diseases. We can learn the true significance of the viruses only by prolonged continuous study; and also we can learn only in this way a sound approach to the proper therapy of virus diseases.

* * * *

Many clinical, pathological and experimental studies indicate that the lipids (fat and fat-like substances), especially cholesterol, are implicated in the etiology of atherosclerosis. Higginbotham *et al.* report on a study of "Intravascular Agglutination of the Blood Following Fat Ingestion" (*Jour. So. Carolina Med. Assoc.*, LII:1, pp. 1-8).

Reduced flow of the blood and changes in vessel

walls frequently follow fat ingestion by man. Nine of ten patients whose case histories indicated severe coronary atherosclerosis, when given a fat test meal developed intravascular agglutination of the blood, reduced blood flow, and typical changes in the vessel walls at a time corresponding to the peak of the expected postprandial lipemia. Anginal pain occurred in some instances.

Similar vascular changes occurred in other patients with a variety of cardiovascular and metabolic diseases following the injection of fat test meals. In a few cases that had only a mild initial agglutination and minimal or no vessel disease there was no detectable change.

The method by which the blood and vessel changes were measured is described in some detail. The authors are of the opinion that dietary fat is an important etiological factor in the production of angina in patients with severe coronary atherosclerosis.

* * * *

The transaminase test in myocardial infarction is evaluated in some detail by Ostrow *et al.* They call attention to the failure in a significant number of cases of acute myocardial infarction to make an unequivocal diagnosis by the usual clinical laboratory or electrocardiographic procedures (*Med. Ann. Dist. Col.*, XXVI:1, pp. 8-12).

An increasing amount of the enzyme, glutamic-oxalacetic transaminase (S-GOT), in the serum following myocardial infarction appears to offer a new means of establishing a diagnosis. The test is easily made with a spectrophotometric assay.

In transmural myocardial infarction the peak values, averaging 100 units per ml., are reached on the first day and return to normal by the fifth day after the onset of symptoms.

In 25 per cent of the authors' cases where only the ST and T waves showed changes in the electrocardiogram following severe anterior chest pains, the S-GOT reached peak values averaging 100 units per ml. The peak level appeared on the average 30 hours after the onset of symptoms and returned to normal (5 to 33 units per ml.) by 60 hours.

The authors stress the diagnostic value of the transaminase test in patients in whom electrocardiographic changes mask an acute myocardial infarction. There was a 100 per cent agreement between the S-GOT diagnosis and the autopsy findings.

Extracardiac causes of S-GOT elevation include hepatocellular damage and acute pulmonary infarction.

* * * *

Adriani and Phillips discuss interestingly "The Use of Endotracheal Cuff; Some Data Pro and Con" (*Anesthes.*, 18:1, pp. 1-14). Despite the almost universal acceptance of the endotracheal cuff and its obvious advantages there is still some objection to its use. The authors call attention to some dangers and possible abuse of the method. Trauma, cardio-respiratory reflexes, reduced ventilation, and the failure to permit free drainage of secretion seem to be the main objections to the procedure.

The conclusion is reached that the dangers of severe trauma, contusions and laceration of the trachea, bronchi or alveoli by rupture of the cuff under ordinary usage have been grossly exaggerated. The incident of cardiac arrhythmias, and reflex circulatory disturbance is no greater with cuffed and uncuffed catheters. The pressure necessary to inflate the conventional endotracheal cuff and effect a seal when the breathing bag is compressed manually ranges between 90 and 220 mm. of mercury. The cuff is 100 per cent effective in preventing the aspiration of gastric contents from the pharynx into the trachea. The pack does not assure against aspiration. The incidence of aspiration when the pack is used is identical to that which occurs when intubation is done without a pack or cuff. The catheter used should be the largest size catheter with the thinnest noncollapsible wall that can be easily introduced into the trachea without force, and the one that assures the least interference with ventilation. Pooling of secretions between the tracheal wall and the catheter occurs only when the steep head-down position is used and the edge of the cuff is at an appreciable distance from the edge of the catheter.

* * * *

For those interested in radio isotopes the April issue of *The Practitioner* (1957) is informative (178:1066, pp. 395-520). Eight English authorities have contributed an equal number of articles on varied aspects of the problem. Beginning with the question of "What is a Radioactive Isotope," they

touch on the preparation, action, use in research, in diagnosis and therapy. There is in addition a discussion of an Hospital Radioactive Isotope Unit and another covering observations on a Combination of Radiography and Radioactive Isotopes.

An editorial calls attention to the fact that many doctors will never handle radioactive isotopes personally, but, it is added, it is essential that they should know something about them, and particularly their use in therapy. The physics of radioactive isotopes for many doctors is wrapped in mystery. It can be written even now that research with radioactive isotopes has a tremendous potentiality in the clarification of many outstanding biological problems.

Perhaps the most significant article in the series is that dealing with hospital radioactive units. The mere facts that such units now exist indicates the advance that has been made in this field in the last decade. Radioactive isotopes are in actual use in clinical medicine.

Research in Cerebral Vascular Disease

Ten medical research centers in nine states have joined in a nationwide cooperative research program to combat cerebral vascular disease. The program, expected to run five or six years and to include eventually 35 to 40 institutions, is under the auspices of the National Institute of Neurological Diseases and Blindness.

The new program was made possible by grants totaling \$172,000 to the various participating organizations. The work will be supplemented by the 29 current projects on various aspects of cerebral vascular disease that are supported by the National Institutes of Health grants amounting to about \$250,000.

The new investigation will make possible a co-ordinated study of thousands of patients who either have suffered a stroke or who show clinical signs indicating that a stroke might be coming on. The research results are expected to shed new light on the nature and causes of strokes and to open the way to more effective treatment methods. Relatively few data are now available on the effectiveness of the various methods currently in use.

The Massachusetts General Hospital in Boston is one of the cooperating institutions.

Doctor Contributions to Medical Schools

The American Medical Education Foundation reports that physicians gave well over three million dollars to medical education in 1956.

The AMEF just released data giving a breakdown of physician contributions to medical education last year. For the first time, this also includes information on contributions made through alumni campaigns. The report showed:

In 1956, 84,657 doctors gave a total of \$3,320,152.14 to the country's 83 medical schools. This total included \$1,072,727 given through the AMEF by 39,892 doctors, and \$2,247,425 given directly to the medical schools by 44,765 doctors.

The AMEF's million-plus contribution is to be used at the discretion of the schools. The new information shows that most of the contributions made through alumni campaigns are also "unmarked," that is, they may be allocated as the deans of the individual schools see fit.

Costs of Nursing Education Estimated

A study of seventeen three-year hospital diploma programs in nursing in the State of Illinois just completed, shows that the average net cost per year of educating a student nurse is about \$680. This is net expense to the hospital after crediting tuition, scholarship and endowment income and hours spent by students on the patient floors during the clinical phase of their education. The latter item is a book figure in which the time of senior students was valued at 90 per cent of the starting rate of the hospital's general duty nurses, 75 per cent for junior students, 50 per cent for freshmen.

The study is part of a proposal to relieve the shortage of registered nurses in the State, since the association sees a larger and larger gap between the demands for nurses and the ability to train and supply them.

Cost Geared Prepayment Programs

"Hospital prepayment programs that are geared to hospital costs afford each segment of a community the link between pooled community funds and the finest of hospital care." Speaking early last month in Chicago, Robert T. Evans, chairman of

the Blue Cross Commission, said that "progress in hospital patient care is moving faster than the community's ability to move with it." "The community," he said, "may accept the additional hospital services, but may not be adjusted to accepting the additional cost." This, he believes, produces a natural gap, which only cost-geared prepayment programs are designed to take in stride. These programs, in effect, offer the people the means for moving parallel with hospital progress and at the same time, offering the nation a method for financing the finest hospital system known to man.

Orinase Now Available

Orinase, the long awaited drug which can be taken by mouth in tablet form and thus eliminate the need for insulin injections in a majority of diabetics, is now available to the medical profession. Orinase can be purchased only upon prescription by a physician.

Dr. E. Gifford Upjohn, president of The Upjohn Company, which developed Orinase in the United States, said the drug, known chemically as a sulfonylurea—a distant chemical cousin of the sulfa drugs—has been under intense and prolonged clinical study and trial in this country since November 1955. Approximately 18,000 of the nation's estimated 1,600,000 diabetics have been given the drug during this period of careful evaluation with no serious adverse side effects. Approximately 1,000 of these have been taking Orinase daily for periods of a year and longer.

Investigators are agreed that Orinase is effective in controlling blood sugar levels in mild to moderate cases of diabetes, particularly in those 40 years of age and older who require 40 units of insulin a day or less.

Alcohol Breath Tests Reported Unreliable

On the heels of the use of alcohol breath tests in many sections of the country by law enforcement agencies now comes the statement from four University of Wisconsin scientists that laboratory tests have proved these devices to be unreliable. The scientists affirm that chemical analysis of blood or urine by a qualified chemist is still the surest method of determining whether a person is under the influence of alcohol.

Poliomyelitis Immunization in 1957

JOHN R. PAUL, M.D., *New Haven*

A review of the current status of the Salk vaccine was given with particular attention to the campaign for the vaccination of adults. Questions of the durability and extent of immunity produced by this vaccine were also considered with particular attention to the manner in which the Salk vaccine is supposed to work and the various lines of defense which the body ordinarily has as a protection against the ultimate invasion of the poliomyelitis virus into the central nervous system. Theoretically the Salk vaccine should protect the individual against the severest form of poliomyelitis, i.e., paralytic poliomyelitis, which, according to the Francis Report of 1955 was accomplished in 1954 in from 60 to 80 per cent of the cases. The Salk vaccine does not protect against the milder, often inapparent, alimentary infections. One might say that this seems fortunate, for it is upon these repeated alimentary infections that individuals may depend to keep their immunity against severe poliomyelitis infection in repair. The question has been raised that, if natural alimentary infection is of value in keeping the vaccinee's immunity in repair, should the matter of reinfection be left to pure chance, or should the use of live attenuated virus vaccination enter the picture as an adjunct for the use of killed vaccine? These latter considerations are at present worthy of discussion, although in an experimental stage. Their practical use is for future consideration.

Abstract of a lecture given at Hartford Hospital, Hartford, Connecticut, May 13, 1957.

Alcoholic Center at Yale in Research Program

The Center of Alcohol Studies at Yale University has been awarded a grant by the National Institute of Mental Health of the U. S. Public Health Service to undertake a research program aimed at devising a yardstick for measuring the results of treatment of alcoholic cases in outpatient clinics.

The grant amounts to \$80,291 and will cover the first two years of the project which is expected to extend over a period of five years. The project was first proposed by the North American association of

Alcoholism Programs, an organization of administrators of thirty-one state-government supported alcoholism treatment programs, and five Canadian Provincial programs.

The ultimate purpose of the project is to determine the effectiveness of the treatment of alcoholics afforded by the various States which spend an estimated \$4,000,000 annually on alcoholism treatment clinics. One feature of the project will be that patients, after thorough diagnostic studies, will be checked regularly and their progress evaluated. In the past, some patients known to have recovered from addictive drinking have disappeared from the records, along with others who have resisted treatment. The research project will attempt to follow every case systematically for five years and also attempt to define reasons why some patients respond to treatment while others do not.

Yale's Center of Alcohol Studies will be in charge of the research. Collaborating with the Yale staff will be several members of the New York University faculty, two of whom, Donald L. Gerard, M.D. and Professor Gerhart S. Saenger, Ph.D., will be principal investigators for the project.

AMA Membership Shows Increase

AMA membership reached 164,128, highest in history, as of last April 30. This probably resulted from changes in the constitution and by-laws admitting members of the reserve components, rather than from any substantial increase in the number of physicians entering the government services and the Armed Forces.

A breakdown of the membership figures follows:

KIND OF MEMBER	AMA	AMA	AMA
	MEMBERSHIP APRIL 30, 1956	MEMBERSHIP DECEMBER 31, 1956	MEMBERSHIP APRIL 30, 1957
Dues paying	132,341	134,307	136,381
Dues exempt	11,200	10,554	9,817
(Total active)	(143,541)	(144,861)	(146,198)
Associate	5,892	6,095	5,856
Service	8,649	9,660	11,713
Affiliate	269	279	273
Honorary	94	93	88
Total	158,445	160,988	164,128

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Paul Winslow Tisher, New Britain
President-Elect, Mrs. Charles Murray Gratz, Cos Cob
First Vice-President, Mrs. Daniel Sampson, Thomaston
Second Vice-President, Mrs. Saul Karpel, New London

Recording Secretary, Mrs. Norman Gardner, East Hampton
Corresponding Secretary, Mrs. Charles N. Sullivan,
 New Britain
Treasurer, Mrs. J. Alfred Wilson, Meriden

BOARD OF DIRECTORS

May 1957 - May 1958

STATE OFFICERS

President: Mrs. Paul Winslow Tisher, New Britain
President-elect: Mrs. Charles Murray Gratz, Greenwich
First Vice President: Mrs. Daniel P. Samson, Thomaston
Second Vice President: Mrs. Saul Karpel, New London
Corresponding Secretary: Mrs. Charles Noyes Sullivan,
 New Britain
Recording Secretary: Mrs. Norman Gardner, East Hamp-
 ton
Treasurer: Mrs. J. Alfred Wilson, Meriden

STATE STANDING COMMITTEE CHAIRMEN

AMEF: Mrs. William Horton, Windsor
Art: Mrs. Orvan Hess, North Haven
Editor: Mrs. F. Erwin Tracy, Middletown
Finance: Mrs. Alfred B. Sundquist, Manchester
History and Necrology: Mrs. Edwin R. Connors, Bridge-
 port
Hospital: Mrs. Willard Buckley, Middletown; Mrs. Ell-
 wood C. Weise, Trumbull
Legislation: Mrs. Irving H. Krall, West Hartford
Legislative Liaison: Mrs. Robert J. Cook, New Haven
Membership: Mrs. Daniel P. Samson, Thomaston
Mental Health: Mrs. Richard B. Brown, West Hartford
National Bulletin: Mrs. Winfield Wight, Thomaston
Parliamentarian: Mrs. E. Roland Hill, Mystic
Program: Mrs. Saul Karpel, New London
Public Relations and Rural Health: Mrs. John N. Galli-
 van, East Hartford
Publicity and Press: Mrs. John D. O'Connell, West Hart-
 ford
Recruitment: Mrs. John A. Bucciarelli, New Canaan
Revision: Mrs. Newell W. Giles, Darien
Safety and Civil Defense: Mrs. Norman J. Barker, Collins-
 ville
School Health: Mrs. James Van Leuvan, Meriden
Today's Health: Mrs. Edward Ottenheimer, Windham
 Center

COUNTY PRESIDENTS

Fairfield: Mrs. William Sinton, Danbury
Hartford: Mrs. Nicholas A. Marinaro, Newington
Litchfield: Mrs. Joseph H. Kott, Torrington
Middlesex: Mrs. Joseph Epstein, Portland
New Haven: Mrs. Edward Wakeman, Bethany
New London: Mrs. Paul Gerity, New London
Windham: Mrs. Bruce R. Valentine, Abington

REPORT OF MENTAL HEALTH COMMITTEE

1956 - 1957

The Mental Health Committee has been active in three areas this year.

1. The active participation, as every year, in the Christmas gift drive for our three State mental hospitals.

2. The gathering of information on the psychiatric facilities for diagnosis and treatment which are available in Connecticut to mentally ill children and their families. This is a research project which was suggested this year by the National Mental Health Committee of the Auxiliary. To aid us in this project we received printed material which was distributed to the county mental health chairmen, who in turn carried out the investigation. A questionnaire sent to me by Mrs. Aaron E. Margulis of Santa Fe, New Mexico, our National Mental Health chairman, will be filled out and mailed back on the basis of the information obtained.

A report recently published by Miss Dorothy Englis, social worker at the Connecticut Child Study and Treatment Home, shows that there were almost 100 children under 16 years hospitalized in the Connecticut State Mental Hospitals in 1956. This is a very high number and a fact which is not generally realized by the public. The State hospitals have no separate facilities for children and therefore the children have to be placed on wards together with the mentally ill adults.

3. Our third activity was the participation in the work of the Hospital Committee of the Greater Hartford Association for Mental Health.

Several of our county mental health committees have been very active this year.

The New Haven County Mental Health Committee, under the leadership of Mrs. Elias Marsh, worked hard and successfully on the Christmas drive for the Connecticut State Hospital in Middletown.

The Middlesex County Mental Health Committee, under the leadership of Mrs. Charles Russman, also was active in the Christmas drive. Besides that, they provided volunteers for work in the hospital and they arranged a mental health meeting for the membership of the Auxiliary with a lecture on the new tranquilizing drugs.

The Hartford County Mental Health Committee, under the leadership of Mrs. Richard Brown, concentrated its activities on help to the Norwich State Hospital and the Connecticut State Hospital at Christmas time as well as throughout the year. They established close cooperation with the Greater Hartford Association for Mental Health and participated in the kickoff dinner for the Mental Health Drive

which was given on April 28, 1957 at the Hotel Statler in Hartford. This was an outstanding affair with Dr. William Menninger as the main speaker, and the Hartford Mental Health Committee of our Auxiliary was well represented among the workers.

The New London County Mental Health Committee, under the leadership of Mrs. Richard Starr, also did an excellent job of service to the Norwich State Hospital. The semi-annual meeting of the New London Auxiliary took place at Norwich. This was followed by an educational tour of the hospital and a meeting with the Director of Volunteer Services. The New London Auxiliary, sparked into action by its mental health committee, provided a total of 125 hours of volunteer service to the hospital and gave four parties for patients. The New London committee also attended a meeting of the Connecticut Association Mental Health and observed National Mental Health Week in 1956 by a public education project through local newspapers.

I think that the activities in the field of mental health have become well focused and mature in our Auxiliary. I want to express my appreciation to all county mental health chairmen for their cooperation and the excellent job they did in this vital field last year.

Respectfully submitted,
Mrs. Richard Karpe, Chairman

ANNUAL REPORT OF NATIONAL BULLETIN CHAIRMAN 1956 - 1957

The National Bulletin of the AMA, published in September, January, March and May, is ordered through the County Treasurer, the County Bulletin Chairman or direct from the Central Office of the Woman's Auxiliary, 535 North Dearborn Street, Chicago 10, Illinois. Quoting from our National Handbook, "The Bulletin presents the programs and aims of the National Auxiliary by means of reports and articles of interest to every member on national, state and county levels. It is a necessary tool for auxiliary officers, committee chairmen and committee members; it is a means of turning 'interested' members into 'informed' members." Our Bulletin offers rapid-reading reviews of significant events; interpretations of problems facing medicine by top AMA officials; exchange of ideas on health education community service and other activities; and news of Auxiliary activities coast-to-coast.

All State Auxiliary Officers and Chairmen are receiving the National Bulletin, as well as a large percentage of County Chairmen. On March 1 the Central Office showed a record of 189 Connecticut subscriptions, with an expected increase before June as renewals are received. Our interested members are urged to subscribe to the National Bulletin to become informed members and to improve the circulation in our State.

Respectfully submitted,
(Mrs. W. E.) Anna E. Wight, Chairman

ANNUAL REPORT OF PUBLIC RELATIONS AND RURAL HEALTH COMMITTEE 1956 - 1957

The Public Relations Chairman and her committee have supervised and taken an active part in promulgating the

following activities which the National Auxiliary considers the prerogative of the Public Relations Chairman: The American Medical Education Foundation, American Medical Education Week, *Today's Health*, Safety, Mental Health, Community Health, Civil Defense, Recruitment, and The Science Fairs.

One of the most successful projects again this year was the Health exhibits at the Connecticut Fairs. The medical exhibits were displayed at fourteen fairs throughout the State and thousands of health education pamphlets, including the First Aid Charts, were distributed by County Auxiliary members to persons attending the fairs.

In addition, the State Public Relations Chairman has been a delegate from this organization to the Connecticut Health League and attended its Annual meeting.

Further, the Public Relations Chairman, as the delegate to the Connecticut Advisory School Health Council, has attended all monthly meetings of, and participated in the proceedings of that organization which this year has produced: (1) "Suggested Procedures for Protection and Release of Children While in School," (2) "Suggested Teacher Reference Guide on the Subject of Fluoridation of Public Water Supplies," and (3) "Qualifications and Functions of School Physicians."

I wish to thank all members of my committee, Dr. William Dobbs, chairman of the Public Relations Committee of the Connecticut State Medical Society, and Mr. James Burch, Public Relations director of the Connecticut State Medical Society, for their excellent cooperation.

Respectfully submitted,
(Mrs. Dewey) T. Sylvia Pitzele Katz

REPORT OF CHAIRMAN OF ART COMMITTEE 1957

In January the Art Committee attended a luncheon meeting at the home of Mrs. Ralph T. Ogden, Art chairman for the Woman's Auxiliary to the Connecticut State Medical Society, to formulate plans for the Annual Art Exhibit which is being held at the East Hartford High School, 777 Burnside Avenue, East Hartford, on April 30, May 1 and 2 inclusive.

Members of the Connecticut State Medical Society, their wives and children are given an opportunity to exhibit their works of art including oil, water color, tempera, pastel, black and white, etchings, photography, sculpture and ceramics. Entry blanks and rules governing the exhibits were sent to all former exhibitors as well as to possible new exhibitors and to each County Chairman. We are indebted to the Connecticut State Medical Society for having these forms mimeographed and mailed.

General information and regulations as well as information for publicity has been mailed by the State Auxiliary Art Chairman to the County Chairmen and to the editor of the Bulletin.

The art exhibits were judged by professional artists on Sunday, April 28.

We wish to express our sincere thanks to all the County Chairmen and members of the Committees, to Dr. John

Freiheit, Miss Lindquist and Dr. Barker for their valuable assistance and cooperation.

Respectfully submitted,
Mary Ann Ogden, Chairman
Kay Giffen, Co-Chairman

REPORT OF TODAY'S HEALTH CHAIRMAN 1956 - 1957

First of all I would like to express my sincere appreciation for the splendid sales record of the county chairmen. Their close cooperation and hard work shows clearly in the following report.

During the year posters, pamphlets, and sample copies of the magazine were displayed at county fairs, libraries, schools, factories, and beauty salons. Nurses, doctors, dentists, and druggists were urged to buy the magazine. Auxiliary members also were urged to subscribe and to give gift subscriptions.

The response was most gratifying and the results show in the credit points listed below.

COUNTY	CHAIRMAN	POINTS
Fairfield	Mrs. E. R. Connors.....	197
Hartford	Mrs. C. L. Smith.....	496
Litchfield	Mrs. J. McKenna.....	61
Middlesex	Mrs. P. Schwartz	103
New Haven	Mrs. H. Caplan.....	220 1/4
New London	Mrs. V. Smilgin.....	83
Tolland		1
Windham	Mrs. A. Laakso.....	45

Total 1,206 1/4

Quota for 1956-57 was 1,187.

Respectfully submitted,
Ruth L. Meyers, Chairman

Major Medical Insurance

Major medical insurance is without valid control to present an unwarranted inflation in the costs of health service, according to Jerome Pollack, FAPHA, writing in the March 1957 issue of the *American Journal of Public Health*. He states that "major medical insurance is an attempt to design an appealing arch without a foundation," but concedes that it may prove to have specialized value for people in the upper income categories who have a greater need for financial protection against excessive costs than for general prepayment. "Persons," he says, "with lower incomes probably continue to need coverage far into minor care, even if this amounts to prepayment rather than insurance." He defines prepayment as "group sharing and advance payment for services expected to be needed."

U.N. and Medical Irradiation

A recent statement by the United Nations Scientific Committee on the Effects of Atomic Radiation about the responsibilities of the medical profession in the use of x-rays and other ionizing radiation ends with the following summary.

(1) The Scientific Committee on the Effects of Atomic Radiation established by the United Nations General Assembly accepts the view that the irradiation of human beings, and especially of their germinal tissue, has certain undesirable effects.

(2) Information received so far indicates that, in certain countries (Sweden, United Kingdom, United States of America), by far the most important artificial source of such irradiation is the use of radiological methods of diagnosis and that this may be equal in importance to radiation from all natural sources. It is possible that such radiation may be having a significant genetic effect on the population as a whole.

(3) The committee is fully aware of the importance and value of the medical use of radiations but wishes to draw the attention of the medical profession to these facts and to the need for a more accurate estimate of the amount of exposure from this source. The help of the medical profession would be most valuable to make it possible to obtain fuller information on this subject.

(4) The committee would be particularly grateful for information through appropriate governmental channels on ways in which the medical irradiation of the population can be reduced without diminishing the true value of radiology in diagnosis or treatment.

THE DOCTOR'S OFFICE

Charles Lanzieri, M.D. announces the opening of an office at Route 69, Wolcott, for the practice of obstetrics, gynecology and sterility.

John F. Beakey, M.D. announces the removal of his office to 287 Collins Street, Hartford.

Ian MacKinnon, M.D. announces the removal of his office for the practice of internal medicine to 1005-E Farmington Avenue, West Hartford.

AROUND THE STATE

Dr. Osborn Honored by Massachusetts

At the Annual Meeting of the Massachusetts Public Health Association held May 2 at the Faculty Club of the Massachusetts Institute of Technology, the Association's Lemuel Shattuck medal was awarded to Dr. Stanley H. Osborn, commissioner of the Connecticut State Department of Health, "for outstanding service in public health."

During the presentation ceremonies, the following citation was delivered by Sophie C. Nelson, retired director of public health nursing of the John Hancock Mutual Life Insurance Co. of Boston:

"The Lemuel Shattuck Award was established in 1950 by the Massachusetts Public Health Association to honor each year a resident of New England selected 'for outstanding service in public health.' The distinguished company of former recipients of the medal now include in the order of their election: Dr. Charles-Edward A. Winslow, Dr. Henry D. Chadwick, Professor Emeritus Curtis M. Hilliard, Dr. Charles F. Wilinsky, Prof. Ira V. Hiscock, Dr. Alton S. Pope, and Miss Sophie C. Nelson. Tonight the Association is proud and honored to add another illustrious name to this growing roster by conferring the Award upon Dr. Stanley Hart Osborn, Commissioner of the Connecticut State Department of Health. New England has many men and women who have rendered 'outstanding service' in the noble profession of public health but it has unhesitating confidence in its selection for this year that it has chosen the most distinguished and most deserving person. It is especially happy that its selection is a native son of Massachusetts though his major contribution to public health has been made in our sister State of Connecticut with which we have so much in common.

"Dr. Osborn, we honor you for a long and illustrious service devoted to promoting the public health in the administrative field. Receiving your medical degree from Tufts College Medical School in 1914, you were faced with the decision of entering the remunerative and rewarding field of private medicine, or of devoting your talents to preventive medicine and public health. You chose to be, in the words of Lemuel Shattuck, one of those 'eminent

medical men who have, as individuals, nobly used the means which their superior position and knowledge have placed within their control, in the prevention of disease, and in the promotion of public health.' The die was cast when you enrolled in the affiliated School for Health Officers of Harvard University-Massachusetts Institute of Technology, which offered such a valuable and unique training, gaining your Certificate of Public Health in 1915. You have since been honored with honorary degrees from Tufts College, Doctor of Science, and from Trinity College, Doctor of Public Health.

"Your professional career started with an assignment with the American Red Cross Sanitary Commission to Serbia and Montenegro, in charge of a Field Unit to combat typhus fever, 1915-16. On your return you were appointed as District Health Officer, Berkshire District by the Massachusetts Public Health Department, and from 1917 to 1920 you were epidemiologist of the Massachusetts Department with a break for overseas service with the Medical Corps of the United States Army.

"In 1920 you were appointed Deputy Commissioner of the Connecticut State Department of Public Health and in two short years became Commissioner, a position you have held ever since through the many vicissitudes in state administration, under both political parties, an extraordinary achievement in itself for a Commissioner, attesting to your tact and skill, as well as the esteem with which you are held.

"The list of professional associations to which you belong, and the offices held are too long to recite. Suffice it to say that they include the major medical and public health organizations, both national and state.

"Your long service for your adopted state has greatly advanced the efficiency and effectiveness of the Health Department work. The consolidation of the original seventeen bureaus into less than a third of that number; the delegation of responsibilities to bureau and division heads; and your extraordinary ability in obtaining increases in your budget appropriations, now give Connecticut one of the outstanding state public health departments. The early

development of a Division of Occupational Health makes you a pioneer in that field. Your vigorous advocacy of the fluoridation of public water supplies in the face of bitter and emotional opposition mark you as a man of courage.

"Dr. Stanley Hart Osborn, in behalf of the Lemuel Shattuck Award Committee, it is my happy pleasure and privilege to bestow upon you the 1957 Lemuel Shattuck Medal for outstanding service to public health in New England."

A Medal for John Paul

The David Russell Lyman gold medal for "outstanding productiveness and service to public welfare" was awarded to Dr. John R. Paul on May 25, 1957. The presentation was made at the Fifty-Fifth Annual Meeting of the Gaylord Farm Association in Wallingford.

Dr. Paul, who came to Connecticut in 1928, has been a member of the Connecticut State Medical Society since 1929 and is the Professor of Preventive Medicine in the Yale Medical School. He is internationally known for his research in poliomyelitis.

Dr. Paul first gained wide recognition in this field when, in cooperation with the late James D. Trask, he first detected the presence of polio virus in sewage. In 1938 he and the Yale Medical School received the first research grant issued by the National Foundation for Infantile Paralysis.

In making the presentation, Dr. Gustaf E. Lindskog, professor of surgery at Yale, said "Dr. Paul's interest in poliomyelitis and other neurotropic diseases, his outstanding accomplishments in rheumatic heart disease, appears to us to appropriately symbolize the changes and broadening emphasis now occurring at Gaylord Farm."

Connecticut Regional Blood Program

At the present rate of collections, the three mobile blood collecting "teams" of the Connecticut Regional Blood Program must make a total of 720 visits to the various communities in the State. The number of bloodmobile visits to a particular community is determined by population.

A mobile unit team consists of a physician, six staff nurses trained in vein puncture and two unit technicians. The personnel of the unit travel in a station wagon driven by one technician, whereas

the medical supplies and equipment necessary to set up a complete medical history section and donor room are transported by a large truck driven by the second technician.

In making the 720 visits, the above six vehicles travel approximately 90,000 miles a year within the boundaries of Connecticut. One important factor that must therefore be considered in the scheduling of operations, done six months in advance, is the travel time required in going to and from the Center in Hartford to the location of a visit.

	JULY 1, 1956 THROUGH MAY 31, 1957	
DONORS	MAY 1957	MAY 31, 1957
Donors accepted	8,656	82,484
Donors rejected	920	8,606
Donors registered	9,576	91,180
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from Center	7,135	69,200
Blood collected by hospitals.....	478	7,564
To fractionation stock pile.....	569	1,476
To out of State hospitals.....	100	1,094
	8,302	79,334
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	63	1,022
Processed into packed cells.....	0	66
Processed into liquid plasma.....	865	9,042
	928	10,130
Discarded—unfit and broken.....	55	612
Grand Total — distribution of blood....	9,285	90,076
Blood returned to Center for processing into plasma and fractions.....	847	8,146
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	40	569
Fresh frozen plasma (125 cc.).....	208	2,047
Serum albumin (100 cc.).....	74	1,720
Immune serum globulin (2 cc.).....	0	3
Packed red cells (bottles).....	0	66
Fibrinogen (bottles)	8	16

Connecticut Legislation

The Connecticut General Assembly passed a bill consolidating the Tuberculosis Commission and the Commission for the Care of the Chronically Ill, Aged and Infirm. It also approved a bill appropriating \$38,000 to the State Department of Health for the establishment of a poison control center and another providing for vocational rehabilitation of handicapped individuals. These were all signed by the Governor.

Fairfield County

The Danbury Medical Society participated recently in a health fair in that city, exhibiting the emergency call telephone system in operation in the State and prepared by the Connecticut State Medical Society.

Physicians of the Bridgeport area were guests of the Pfizer Company for golf and dinner at the Brooklawn Country Club last month.

The annual dinner dance of the Stamford Medical Society was held June 27 at Laddin's Terrace, Stamford.

Rolando R. Ruiz, 208 Main Street, Danbury, reopened his office for the practice of medicine on June 1.

According to the Regional Plan Association, a population of 800,000 is predicted for Fairfield County by 1975, or 245,000 more than the 1955 figure.

Charles B. Gaffney of Bridgeport died in St. Vincent's Hospital, Bridgeport, on May 24 at the age of 55.

Hartford County

The Hartford Heart Association recently announced grants totaling \$17,000 to support heart research at the Hartford Hospital Cardio-Respiratory Laboratory. The grants will support three research projects being conducted at the hospital. One grant will be to Dr. Charles E. McLean, director of the laboratory to continue developing a new method of diagnosis of heart disease through study of the special pulse characteristics. The study involves comparison of blood pressure patterns made by the pulse as a method of diagnosing aortic stenosis.

The second grant is for Dr. Thomas J. Donovan to continue work started in 1956 on development of a new surgical method for aortic stenosis. He is trying to devise a method of "building a new blood vessel around . . ." the stenosis. The third grant is for a new project being conducted by Dr. Henry B. C. Low. He is working on a technique to permit surgeons to operate inside the heart while the patient's blood continues to circulate through the body as the result of pumping through a machine designed to take the place of the heart and lungs during the surgical procedure. Dr. McLean's grant will amount to \$4,590, Dr. Donovan's \$6,120 and Dr. Low's to \$6,290.

Participating in the program of the Yale School of Medicine and the American Rhinologic Society recently are William J. Neidlinger and Charles A. Tucker. Dr. Neidlinger will lecture on "Making and Taking Preoperative Photographs," and Dr. Tucker will talk on "Preparation of the Patient."

Elected president of the medical staff of the New Britain Memorial to succeed Alfred J. Berger is Francis S. Buccheri. Dr. Buccheri is also a member of the staff of the New Britain General Hospital. He is a graduate of Tufts Medical School and is a veteran of World War II. Other officers who will serve for the next year are: Ludmil Chotkowski, vice president and Edward Resnik, secretary. Harry Parlato, Mario H. Yanello and Alfred Berger were elected executive committee members.

Heading up a professional workshop on mental retardation sponsored by the Greater Hartford Association for Retarded Children recently was Dr. Frederick J. Flynn. Participating in the workshop were: Drs. Theodore Goldstein, Frank McCarthy, Jean Wells, Joseph Bellizzi, Louis Spekter, Burwell Dodd, Edward Wilmer and Francis Lundborg.

Panelists in a meeting sponsored by the Hartford Hospital Association recently were: Burdette J. Buck, Theodore Steege, Wilson Fitch Smith and Edward Scull. Moderator for the program which was called "Can you be fat and healthy?" was Dr. Stewart Seigle.

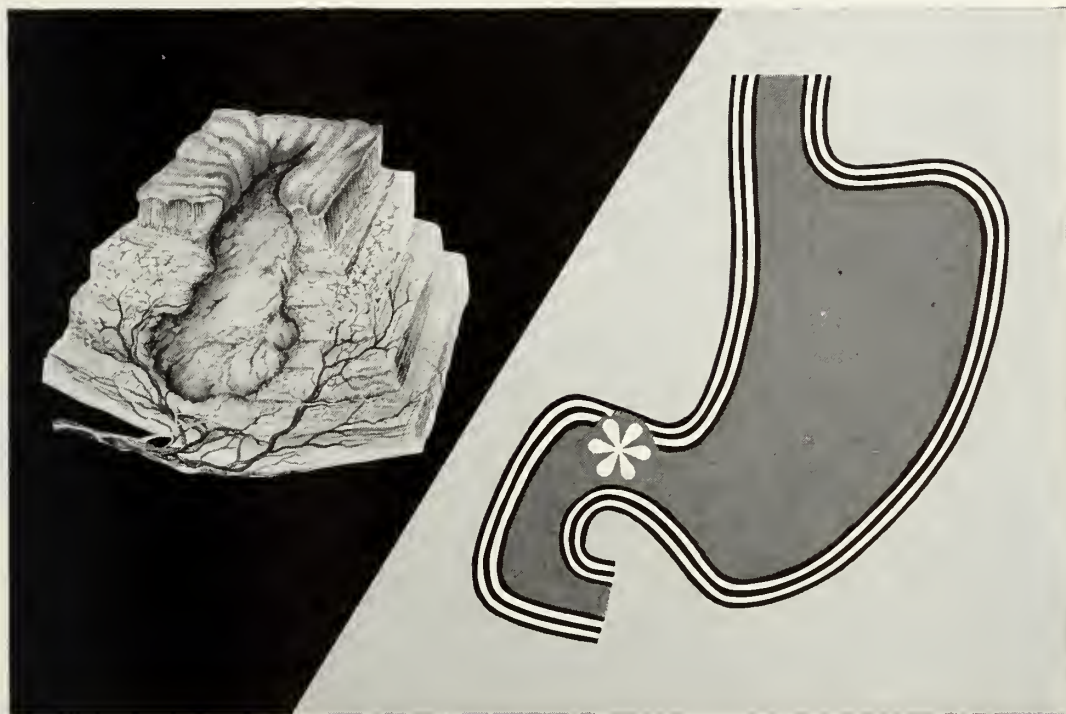
New chairman of the Council of the Connecticut State Medical Society is Dr. John N. Gallivan, president of HCMA.

John E. Cartland, Jr., Alexander Menzer and Samuel D. Rowley, all of Hartford, have been elected to membership in the American Academy of Pediatrics.

Charles W. Goff of Hartford is participating in the first American Congress of Legal Medicine and Law Science Problems being held this month in Chicago.

Peter J. Scafarello, secretary of the Connecticut Academy of General Practice, attended a ten day refresher course at Fort Lauderdale, Florida given by the Minnesota Medi-Clinics and cosponsored by the Florida Academy of General Practice.

Ralph T. Ogden, immediate past president of the State Medical Society, was elected president of the American Radium Society at its recent meeting in Quebec. The late Douglas J. Roberts was to assume this office since he became president-elect at the meeting of that society one year ago.

BROAD ANTICHOLINERGIC BLOCKADE

Pro-Banthine® Relieves Pain, Accelerates Peptic Ulcer Healing

The efficiency of Pro-Banthine (brand of propantheline bromide) in inhibiting the chemical substance which mediates parasympathetic gastric activity explains the success of the drug in ulcer therapy. Pro-Banthine blocks acetylcholine at both the ganglia and parasympathetic effector sites. This dual action controls excess neural stimulation of both gastric secretion and motility.

The therapeutic benefits of this anti-

cholinergic blockade consist, as many clinical investigators have noted, in prompt relief of ulcer pain and pronounced acceleration of ulcer healing.

The suggested initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. Two or more tablets four times a day may be indicated in severe manifestations. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

Francis J. Braceland of Hartford received a standing ovation at the 113th annual meeting of the American Psychiatric Association as he finished his presidential address on "Psychiatry and the Science of Man." Also on the program were John J. Blasko, State mental health commissioner, and John Donnelly of Hartford, acting medical director of the Institute of Living.

The new president of the Association for Research in Nervous and Mental Disease is Francis J. Braceland, psychiatrist-in-chief of the Institute of Living.

Three Hartford orthopedic surgeons were honored at the annual dinner of the Newington Home and Hospital for Crippled Children held on May 23. All three of these men, Frank S. Jones, John W. Larrabee, and Charles W. Goff, have served the Newington Home for the past 25 years without any financial return. Each was presented with a handsome hand engraved certificate.

Marcel Thau of Hartford has been named state chairman for the 200th anniversary celebration of LaFayette's birth next September. The appointment was made by the National LaFayette Bicentennial Committee in New York City.

The Bristol Hospital received, on its 37th anniversary, \$34,800 from the Ford Foundation March 15. The money was the second payment of the original \$69,600 grant the Foundation pledged to the hospital last year when over \$200 million was awarded to 3,200 voluntary, non-profit, non-governmental hospitals in the United States, Alaska, Hawaii, and Puerto Rico.

The United States Atomic Energy Commission has authorized the Bristol Hospital to use radioactive isotopes for diagnosis and therapy under the direction of Ralph J. Littwin, M.D., the hospital's radiologist. The AEC's action marked the first time that any radioactive by-product has been approved for use at the hospital.

Middlesex County

Three of the interns at Middlesex Memorial Hospital ended their tour of duty June 30. Pascal Grellety is returning to France. William Cobain is going to the Health Department in Arlington, Virginia for training in public health. Edgar Cathcart is going to New England Deaconess Hospital for training in internal medicine.

Paul Hunter, who interned in New Britain, has joined Charles W. Chace in general practice.

Andrew Turano was recently elected president of the Middlesex Chapter of the American Heart Association.

Hazen A. Calhoun died suddenly at the age of 50 while on vacation in Massachusetts. He had been in general practice in Higganum since 1940 and before that had practiced in Middletown for a short time.

New Haven County

Herman S. Sachs of New Haven, a child psychiatrist, has been appointed executive director of the Mid-Fair Child Guidance Center. This Center is jointly sponsored by the towns of Weston, Westport, Wilton, Fairfield, Norwalk and Darien and will open in October at or near Norwalk Hospital.

New London County

John D. Donohue, medical examiner of the town of Montville and health officer there for the past 24 years, died at his home in Montville on May 13 at the age of 72.

Windham County

Sidney Vernon of Willimantic discussed "Nocturia: Significance and Management" at the first morning session of the 14th annual meeting of the American Geriatrics Society held in New York City in May.

Yale University School of Medicine

Theodore Litz, professor of psychiatry, was selected at the recent annual meeting of the American Psychiatric Association to make the award of the Association's \$1,500 Hofheimer Prize to Dr. Christoph M. Heinicke, senior research psychologist at the Tavistock Clinic, London, England. Fritz C. Redlick, chairman of the Department of Psychiatry, participated in one of the sessions of the American Psychiatric Association meeting.

John F. Fulton, Sterling professor of the history of medicine at Yale, received an honorary doctor of letters degree from Oxford University in England this June. Sir Laurence Olivier was similarly honored at the same convocation. Both were cited for distinguished contributions to English letters.



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SPECIAL NOTICES

International Association of Gerontology
Merano, Italy
July 14-19, 1957

Fourth International Congress of Clinical Pathology
Brussels, Belgium
July 14-20, 1957

Third International Congress of Neuropathology
Brussels, Belgium
July 21-29, 1957

Meeting of the International League Against Epilepsy
Brussels, Belgium
July 21, 1957

Sixth International Neurological Congress
Brussels, Belgium
July 21-28, 1957

International Congress of Electroencephalography
and Clinical Neurophysiology
Brussels, Belgium
July 21-29, 1957

First International Congress of Neuro-Surgery
Brussels, Belgium
July 21-29, 1957

Seventh World Congress of the International Society
for the Welfare of Cripples
London, England
July 22-26, 1957

Symposium on Cancer
Perugia, Italy
July 24-29, 1957

Fourth International Congress on Nutrition
Paris, France
July 26 - August 1, 1957

Twentieth International Congress of Psychoanalysis
Paris, France
July 28 - August 1, 1957

Eleventh International Congress of Dermatology
Stockholm, Sweden
July 31 - August 6, 1957

Fifth Pan-American Congress of Paediatrics
Lima, Peru
August 5-10, 1957

Tenth Annual Meeting of the World Federation
for Mental Health
Copenhagen, Denmark
August 11-17, 1957

Second World Congress of Psychiatry
Zurich, Switzerland
September 1-7, 1957

INTERNATIONAL CONFERENCE OF ULTRASONICS IN MEDICINE

Sponsored by the American Institute of Ultrasonics in Medicine, Statler Hotel, Los Angeles, California, September 6-7, 1957. John H. Aldes, M.D., secretary, 4833 Fountain Avenue, Los Angeles 29, California.

The meeting will cover the biological and physiological principles, as well as the clinical aspects of ultrasonics in medicine. There will also be a round table conference covering all these phases. Participating in the meeting will be representatives from Europe, South America and Japan.

International College of Surgeons—22nd Annual Congress
Chicago, Illinois
September 8-12, 1957

Seventh Congress of the International Society of
Orthopaedic Surgery and Traumatology
Barcelona, Spain
September 16-21, 1957

Seventh Congress of the International Union of
Railway Medical Services
Paris, France
September 25-30, 1957

Association of Clinical Pathologists
London, England
September 26-28, 1957

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International Conference on the Influence of Living
and Working Conditions on Health
Cannes, France
September 27-29, 1957

Eleventh General Assembly of the World Medical
Association
Istanbul, Turkey
September 29 - October 5, 1957

Fifteenth International Congress of Military Medicine
and Pharmacy
Beograd and Opatija, Yugoslavia
September 29 - October 5, 1957

PAN-PACIFIC SURGICAL ASSOCIATION SEVENTH CONGRESS

Honolulu, Hawaii, November 14-22, 1957

The Seventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, November 14-22, 1957. All members of the profession are cordially invited to attend and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program by leading surgeons with sessions in all divisions of surgery and related fields promises to be of interest to all doctors.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii.

NATION'S OLDEST ESSAY CONTEST

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Hormonal Relationships in Breast and Prostatic Cancer—Their Practical Application." The dissertation must be type-written, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered. Essays must be submitted by December 31, 1957.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

UROLOGY AWARD

The American Urological Association offers an annual award of \$1,000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Roosevelt Hotel, New Orleans, Louisiana, April 28 - May 1, 1958.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1957.

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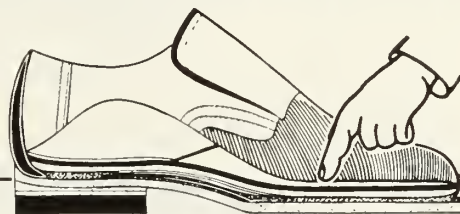
NEW BOOKS IN REVIEW

LIVER, BILIARY TRACT AND PANCREAS. By Frank H. Netter, M.D. Part III of Volume 3, *The Digestive System*, the Ciba Collection of Medical Illustrations, Ciba Pharmaceutical Products, Inc., Summit, New Jersey. 1957. 133 full color plates. 165 pp. \$10.50.

Reviewed by DAVID BABBOIT

If one agrees with the adage that "one picture is worth a thousand words," then an illustrated volume about a given topic should be more meaningful than one without illustrations. Further, if the artist is Dr. Frank Netter working in collaboration with men as qualified in their field as Dr. Oscar Bodansky, Hans Popper and others, their combined efforts are bound to be a success—and this is the case. For bound

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in one volume of 165 pages are over one hundred and thirty full color plates with appropriate and concise commentary by Dr. Netter's consultants in this endeavor. The artist and his collaborators approach the various facets of the subject in a logical and progressive fashion, dealing first with the anatomy of the liver, biliary tract and pancreas and moving on to the physiology, pathophysiology and functional tests concerned with these organs before devoting the major portion of the book to diseases of the liver, biliary tree and pancreas. A new feature has been included in this volume of the Ciba Collection of Medical Illustrations. For the first time a list of references has been included. This is a valuable addition.

Dr. Netter stresses that this volume is not intended to substitute for any existing text, and that as, the name implies, the work is a collection of medical illustrations. If the reader keeps this in mind it would be difficult to be disappointed in this book. There are a sufficient number of "purely" anatomical illustrations to bolster the floundering anatomist; the illustrations accompanying the descriptions of the various functional tests discussed add impact to these subjects, and the artistic coverage of the diseases of the organs is equal to Dr. Netter's best.

Work on other parts of Volume 3 (to deal with the remainder of the gastrointestinal tract) is underway. This reviewer looks forward to their completion.

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PHYSICAL EXAMINATION IN HEALTH AND DISEASE. Second edition. By Rudolph H. Kampmeier, M.D.
Philadelphia: F. A. Davis Company. 1957. 774 pp. \$9.50.

Reviewed by ROBERT S. GORDON

Dr. Kampmeier has intended this volume for the student. It deals with the fundamentals of the physical examination. There is an outline of the plan and technique for taking a medical history. He is very comprehensive in his discussion, carefully pointing out the many pitfalls one may encounter by inadequately phrasing or developing certain aspects of the history.

As indicated by the title, he initially describes the physical findings in the normal individual and variations thereof, together with the proper method of performing the examination. There next follows a description in disease. This pattern is followed in an orderly fashion for all the component parts of the complete physical examination. For example, there are three chapters dealing with the examination of the abdomen: the normal and its variants; general findings in disease; and a description of diseases whose major signs are related to the abdomen, emphasizing the physical findings in such diseases. The book is well illustrated with black and white photographs. There are very helpful supplements; in many instances, however, much more could be offered by color plates.

The systematic and orderly presentation of the material, as well as the extremely comprehensive coverage of the subject, makes this volume an important contribution to the student of physical diagnosis. Fundamental as it is, practitioners as well as medical students can benefit from it, for although new laboratory and x-ray techniques are becoming more and more available, there is no substitution for a careful physical examination as an aid in medical diagnosis.

NERVOUS SYSTEM. By Frank H. Netter, M.D. Volume I, The Ciba Collection of Medical Illustrations. Summit, New Jersey: Ciba Pharmaceutical Products, Inc. 1953. 104 full color plates, 143 pp. \$6.

Reviewed by DAVID BABBOTT

In 1948 Ciba first published in book form a number of Dr. Frank Netter's illustrations. This volume, containing no new works and with no major attempt at organization of the material, was enthusiastically received and was the forerunner of the now established Ciba Collection of Medical Illustrations. Three of these, dealing with the Nervous System, Reproductive System and the Liver, Biliary Tract and Pancreas (part of a volume on the Digestive System) are available today. Others are underway.

Volume I, the Nervous System, is divided into five sections: Anatomy of the Spine, The Central Nervous System, Functional Neuroanatomy, The Autonomic Nervous System, and Pathology of the Brain and Spinal Cord. The latter section, the largest, includes infectious, degenerative, neoplastic and traumatic affections of the nervous system. Throughout the volume an attempt has been made to stress the functional and clinical aspects of the subject matter, both in Dr. Netter's magnificent illustrations and in the succinct and descriptive accompanying texts by Drs. Abraham Kaplan, Gerhardt von Bonin and Albert Kuntz.

ESTABLISHED 1890

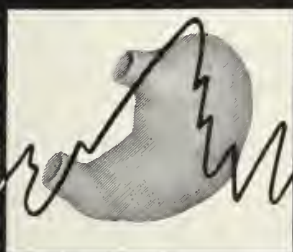
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SEARLE

Without doubt it is the artistry of Dr. Netter that "makes" the book. The masterful simplicity of his portrayal, his artistic use of color and the realistic quality to his illustrations all contribute to the educational value of the work. Its clinical orientation and logical presentation serve to heighten its usefulness to the medical student, house officer or practicing physician whose texts and monographs will likely remain on the shelf in favor of this quick but comprehensive review, compliments of Dr. Netter.

HISTAMINE. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. and C. M. O'Connor, B.Sc. Published under auspices of Ciba Foundation. Boston, Mass.: Little Brown and Co., and London, England: J. and A. Churchill Ltd. 1956. 472 pp. \$9.

Reviewed by R. V. LAMOTTA

This book is a rather complete and involved account of histamine chemistry and physiology dedicated to the memory of Sir Henry Dale. It contains many articles by active research workers from all parts of the world.

The symposium begins with a discussion of histamine distribution in the body. In the very first article, the reader is cautioned of the fact that the distribution of histamine varies in different species and this must be borne in mind lest erroneous conclusions or generalizations be drawn. The analysis of tissue histamine content is interestingly presented by the graphic and anatomical "histamine profile." In the case of the upper gastrointestinal tract, the "histamine profile" certainly suggests that a large part of the histamine in the stomach and pylorus occurs in the gland cells.

The consensus of most studies indicate that the mast cell is rich in histamine and the histamine content in many instances is correlated with the number of mast cells. It is also suggested that heparin or other substances within the mast cell form a complex with certain excitatory materials with a resultant change in the mast cell contents leading to histamine release.

The evidence supporting the existence of tissue and excretory conjugated histamine is presented, but in general it is felt that most of the tissue histamine is more or less free

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except that it is within certain intracellular particles. Further, a provocative scheme for the interaction of different kinds of histamine releasing substances is presented but the actual mechanisms involved still require much clarification.

There are numerous other articles of a very technical nature involving the origin, metabolism and fate of histamine with special reference to the enzyme histaminase. In general they are of a highly technical nature and their appeal is therefore limited. The book is in legible type and the articles are well endowed with graphs, tables and illustrations.

INTERNAL SECRETIONS OF THE PANCREAS. Edited by G. E. W. Wolstenholme, F.R.C., M.A., M.B., B.Ch. and C. M. O'Connor, B.Sc. Published under auspices of Ciba Foundation. Boston, Mass.: Little Brown and Co. and London, England: J. and A. Churchill Ltd. 292 pp. \$7.

Reviewed by R. V. LAMOTTA

This book is a compilation of recent studies dealing with the internal secretions of the pancreas. The many subjects under discussion represent concise resumés of what is known or is being investigated at the present time. The book covers certain interesting aspects of insulin, glucagon and hormonal interrelationships. The authors are distinguished men in

the field and almost every chapter is followed by a discussion period involving other prominent investigators.

The book begins with a discussion of morphological studies on the x cells and their experimental destruction by Synthalin A and IPTD (p-aminobenzenesulphonamidoisopropylthiodiazole). It would appear that Synthalin A is a selective mitotic poison on dividing x cells of the pancreas in the young rat. This adds impetus to the many studies already in progress involving the x cells and glucagon production. It is obvious from the discussion which follows that much remains to be learned concerning the hyperglycemic-glycogenolytic factor. Its role in humans is still not apparent.

Hormonal interrelationships are discussed by several observers. A pertinent point to be kept in mind is that their physiological studies are done in experimental animals and need not hold true in humans. In this regard, one cannot dismiss the role of glucagon in humans even though glucagon "diabetes" has not yet been permanently induced by animal injection experiments.

Many other subjects of great interest are discussed in this book. However, many of the topics are of such a complicated and technical nature that they have a limited appeal. The book is well illustrated and of legible type.

The CONNECTICUT STATE MEDICAL JOURNAL

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PRODROMAL MALIGNANT GLAUCOMA

HENRY L. BIRGE, M.D., *Hartford*

FAILURES in the surgical management of malignant glaucoma^{1,4,7,16} call attention to the syndrome of prodromal malignant glaucoma, in which success has been reported.²⁸ Based on a new and possibly radical operation performed^{24,25,26,27,28} before the devastating complications which give rise to malignant glaucoma can occur, this new concept of an old problem offers some hope to the otherwise hopeless individual afflicted with malignant glaucoma.

DEFINITION

Von Graefe (1869) described malignant glaucoma as "a new and acute glaucomatous process brought about by surgery, and which is unusual only in the continued failure of the anterior chamber to form." The increasing intraocular tension which followed this series of events was usually treated by surgical procedures on the lens, sometimes with less than desired success.^{5,6,7,8}

Prodromal cases can be defined preoperatively as those in which there is more likelihood of lenticular complication arising than in other cases of glaucoma. They can be specifically diagnosed before any surgery, in the majority of cases.

SIGNS AND SYMPTOMS OF PRODROMAL MALIGNANT GLAUCOMA

Each case of chronic noncongestive glaucoma in which any of the following additional findings occur is in danger of developing malignant glaucoma after surgery.

Prodromal malignant glaucoma occurs when the eye is too small, as in microcornea,⁷ or when the lens is too large, as in acquired myopia⁴ after surgery or cataract formation, extreme hyperopia, extreme age, and usually, although not always, in narrow angle glaucoma.⁹

The Author. *Associate Ophthalmologist, Hartford Hospital; Assistant Clinical Professor of Ophthalmology, Yale University School of Medicine*

SUMMARY

Prodromal malignant glaucoma can be treated surgically before it has developed into malignant glaucoma. The operation of choice is lens extraction combined with a filtration procedure, performed at one sitting to avoid multiple operations.

The operation is indicated when the intraocular tension begins to become uncontrollable as, for instance, when pilocarpine of more than a four per cent solution is required at two hour intervals or less.

Case reports are included to illustrate the cure of prodromal malignant glaucoma in a single eye, even in the presence of malignant glaucoma in the other eye.

When the syndrome of prodromal malignant glaucoma is diagnosed, the importance of any lens factor is recognized, and with proper treatment the "new and acute glaucomatous process" specified by Von Graefe can be avoided.

The importance of recognizing an overly large lens before surgery cannot be underestimated if malignant glaucoma is to be prevented. The diagnosis must be arrived at in the prodromal stage if preventive measures are to be successful.

The prodromal stage of malignant glaucoma usually exists for many months before the lens is displaced forward by the surgical procedures designed to alleviate the chronic glaucoma. Ample time for study and reflection before glaucoma surgery is available to the surgeon in most cases. Despite the difficulty of measuring the size of the lens, there

Presented at the sectional meeting, American College of Surgeons, San Juan, Puerto Rico, Preliminary Scientific Program, January 9, 1957 aboard S.S. Homeric

are several methods which serve adequately, if only the surgeon will raise his sights from the problem of glaucoma alone to include as well the behavior of the lens.

In the usual course of events, malignant glaucoma occurs in both eyes, frequently at different times. Following the loss of the first eye from malignant glaucoma, the prodromal stage should easily be recognized in the second eye.

The recognition of the prodromal stage of malignant glaucoma in the first eye offers gratifying possibilities in that the loss of the first eye may be avoided, and treatment of the second eye is often thereby facilitated.¹⁷

MANAGEMENT OF PRODROMAL MALIGNANT GLAUCOMA

Simultaneous consideration of the two etiologic processes which, in their joining, produce malignant glaucoma can most profitably be accomplished in the prodromal stage.

Glaucoma is managed medically while it is controllable. As soon as surgical measures are indicated, the importance of the lens becomes paramount.

Removal of the lens before it becomes jammed into the narrow anterior chamber through forward displacement is the method most likely to be successful, both theoretically and practically, for the prevention of malignant glaucoma.

At the time of lens removal, glaucoma surgery such as sclerectomy or iridencleisis can easily be added to the lens extraction.^{24,26,27,28} Glaucoma surgery can be done at a later time when multiple operations are not contraindicated, although it is more advantageous to do all the surgery at one time. Surgical treatment aims to produce simultaneous relief of both factors which lead to malignant glaucoma, namely chronic noncongestive glaucoma, together with the dangerously enlarged lens.

The presense of cataractous changes is considered of prime importance only in cases that do not belong in the category of prodromal malignant glaucoma.

In prodromal malignant glaucoma the state of clearness of the lens is a minor consideration. The increased size of the lens in relation to the eye or the anterior chamber determines the indication for lens removal.

A large clear lens can produce malignant glaucoma and therefore must be removed in the prodromal stage. Fortunately most clear lenses in my experience have, upon removal, given clinical evidence of cataractous changes, even though these

were not visible ophthalmoscopically through the miotic pupil.

CASE REPORTS

CASE 1

Illustrative of cure of prodromal malignant glaucoma and benign effect on second eye of double operation on first eye. 10 year follow-up.

In 1946 this 70 year old man reported with complaints concerning his right eye. Refraction showed that he had developed acquired myopia of -1.00 diopter in the right eye and that the left eye remained plus 1.50 hyperopic. A slight elevation of ocular tension was noted (35 mm. Hg.). This was controlled by 1 per cent pilocarpine twice a day for eight months, then the dosage had to be increased to four times a day. Faint lens changes were noted in 1947, but vision was 20/20 in each eye with glasses.

The tension in the right eye gradually required increasing doses of pilocarpine to 4 per cent four times a day and then six times a day, right eye. The anterior chambers were quite narrow. The tension in the left eye never required more than 2 per cent pilocarpine three times a day to stay controlled.

Operation on the right eye was performed for the swollen lens and narrow angle glaucoma on March 18, 1952, an extra capsular extraction being obtained and an iridencleisis being performed at the same time. Following this, no miotic has been required in the right eye, and vision in 1956 is 20/20 with correction. The bleb is atrophic.

The left eye is still under control with 2 per cent pilocarpine five times a day, tension 23, and vision 20/25. No acquired myopia has yet occurred in the left eye, but the anterior chamber is less than 1 mm. deep.

CASE 2

Illustrative of restoration of vision and normal tension in second eye with prodromal malignant glaucoma, after loss of first eye in malignant glaucoma.

This 82 year old female had narrow angle glaucoma for 12 years prior to our knowledge. Her right eye had been operated for acute glaucoma, an iridectomy having been performed in 1948. A mature cataract was present in the right eye in 1954. This eye was controlled by 2 per cent pilocarpine three times a day with ¼ per cent Eserine at night. There was poor light projection.

Her left eye had vision of counting fingers only. Every morning she looked for the light in her bedroom to see whether it was there and whether she could still see. She was under care for blindness, using talking books and having people read to her.

Her tension in the left eye remained controlled with pilocarpine and Eserine until an automobile accident in December, 1954. Thereafter, even with pilocarpine 4 per cent, five times a day, the tension in the left eye rose to 48, while the tension in the right eye was 40 mm. of mercury.

In spite of her age an operation was performed, and the cataract removed from the left eye, with iridencleisis, so that her vision eighteen months later was 20/30. Her field

was only 10°. The diagnosis was chronic narrow angle glaucoma with mature cataract, or malignant glaucoma.

She required no further miotic therapy and maintains a good bleb.

CASE 3

Illustrative of effect of multiple operations in bilateral chronic narrow angle glaucoma with clear lens. Microphthalmos. Prodromal malignant glaucoma.

This 65 year old female with chronic narrow angle glaucoma in eyes with a corneal diameter of 10 mm. and hyperopia of plus 3.00, plus .50 X 90, O. U., had 20/20 vision in each eye. She had had glaucoma since 1951 and was using 2 per cent pilocarpine five times a day in each eye to keep her tension moderately controlled at right 23 and left 27 mm. Hg. The lenses were clear. A psychiatric consultation for her anxiety was performed, but no additional help was available since her fear of blindness was based on organic disease.

When her tension rose to 50 mm. Hg. in the left eye and remained elevated from March 23 to April 18, 1955, an iridencleisis with sclerectomy was performed on the left eye. This resulted in a 1 cm. bleb and controlled the tension in the left eye in spite of synechia and iritis, but a cataract developed which was removed in June, 1956 followed by discission. This eye (left) in December, 1956 has vision of 20/70. The right eye has 20/20 vision and is still under therapy with 8 per cent pilocarpine every two hours.

This case illustrates that removal of a clear lens in the first eye would have been advisable and would have saved her from multiple operations. That procedure will be followed in the near future on the second eye.

CASE 4

Illustrative of malignant glaucoma over a 13 year period.

This 60 year old female was first seen in March, 1953. Her left eye was blind since glaucoma surgery elsewhere in 1943. She reported she had seen ten doctors at that time and that the vision was severely impaired before diagnosis and

surgery were performed. Her left eye now shows a mature cataract, old iridectomy, and synechia. She shows a mild chronic anxiety state.

Her right eye sees 20/25 with plus 3.50 sphere and has a 9 mm. corneal diameter. Her right field is still good but shows a nasal loss. There is a large glaucomatous excavation in the nerve head and she sees halos and has frontal headache at intervals.

She is still being carried on medical treatment which is outlined in the following table, but operation is anticipated in the near future.

This is certainly prodromal malignant glaucoma in the second eye. The tension variations are glaucomatous. The lens factors are beginning to occur; there is acquired myopia but no cataract.

In a microphthalmic one-eyed, 60 year old with prodromal malignant glaucoma the operation of choice is lens extraction with filtering operation.

CASE 5

Illustrative of prodromal malignant glaucoma (in a large eye), from 1949 through 1956, complicated by hypertension, cardiac failure, allergy to all glaucoma medication, eventual operation with restoration of vision and normal tension, three weeks after combined operation. A nervous one-eyed, individual of 75 years of age.

ABSTRACT OF RECORD

When first seen on September 7, 1949 the left eye was blind from undiagnosed glaucoma. The tension in the right was 25 and the left, 65 mm. of Hg. The patient refused surgery because of fear and the necessity to care for her ailing husband.

She was treated with 1 per cent pilocarpine b. d. in the right eye (20/25) and 4 per cent pilocarpine with Furmetide 10 per cent at frequent intervals in the left eye until she developed a local dermatitis in August, 1950. A change of medication to prostigmine benefited her until April, 1952 when she was changed to Eserine. This worked until

DATE	VISION		TENSION		TREATMENT	
	R	L	R	L	R	L
March 18-53	20/25	Blind	29	22	pilo 1% bd	none
April 8-53	20/25 c gl	Blind	25	22	pilo 1% bd	none
May 7-53	20/25 plus WC	Blind	29	20	pilo 1% t.i.d.	none
June 5-53	20/25 WC	Blind	26	20	pilo 2% q6H	none
June 19-53	20/25 WC	Blind	30	22	pilo 2% q3H	none
September 9-53	20/25 WC	Blind	25	20	pilo 2% q3H	none
December 14-53	20/25 WC	Blind	25-27	20	pilo 2% q3H	none
February 24-54	20/25	Blind	27-29	20	pilo 2% 6 i.d.	none
May 18-54	20/25 WC	Blind	22	20	pilo 2% 6 i.d.	none
December 24-54	20/25 WC	Blind	27-30	20	pilo 2% 6 i.d.	none
September 7-54	20/30 WC	Blind	25-27	15	pilo 2% 6 i.d.	none
January 26-55	20/25 WC	Blind	20-23	17	pilo 2% 6 i.d.	none
April 27-55	20/25 WC	Blind	23	soft	pilo 2% 6 i.d.	none
August 3-55	20/25 WC	Blind	24-27	17	pilo 3% 6 i.d.	none
December 15-55	20/25 plus WC	Blind	37-40	20	pilo 4% q2h	Phenobarb.
February 23-56	20/25 WC	Blind	27	23	pilo 4% q2h	Phenobarb.
April 25-56	20/25	Blind	22	soft	pilo 4% q2h	Phenobarb.
August 15-56	20/25	Blind	27	soft	1 D acquired myopia	
November 21-56	20/20	Blind	27	soft	Same—nervous over holidays	

February, 1953, when she went back to pilocarpine in the right eye 2 per cent t. i. d. and left eye 6 per cent q3h. In June, 1953 the pilocarpine had to be increased in the right eye to 4 per cent q3h and she had nearly constant chronic lid allergy, in spite of antihistamine drugs and changes in medication.

Her vision in the right eye gradually failed to 20/50 by mid-1955. She refused operation, even though the tension occasionally registered 34 to 40. There were a few hypertensive retinal hemorrhages seen from time to time, and she survived one spell of cardiac decompensation in 1954.

Her right eye by March 1956 had almost no anterior chamber, and an immature cataract, and was frequently red from the allergic conjunctivitis. Diamox kept the right eye tension fairly well controlled until operation on October 23, 1956.

She now has a restoration of vision to 20/30 or 20/40 without medication, and for the first time in years has clear skin and a white eye. Her bleb is small and draining well. The left eye will, of course, have to be removed when it becomes painful.

CASE 6

Illustrative of an explosive type of prodromal malignant glaucoma in an executive with microcornea; restoration of vision and tension and ability to work in five weeks following surgery.

This 61 year old man noted that his glasses were not comfortable on March 2, 1956. At this time the tension was 65 in the right eye and 48 in the left. His vision was 20/40 in the right eye and 20/20 in the left. He was placed on 2 per cent pilocarpine without much improvement in his tension.

Four per cent pilocarpine kept the tension under control until September, 1956. Six per cent pilocarpine was prescribed on September 24, 1956, but the tension in the right eye was never able to be restored to the 20's. Tension in the left eye was 25 on 8 per cent pilocarpine six times a day with two Diamox tablets in addition.

After consultation, the patient returned for operation which was performed on October 9, 1956. The lens was removed from the right eye and a sclerectomy with iridencleisis was performed.

Five weeks after operation the vision was restored with an aphakic glass to 20/30 without any medication.

The left eye is being carried on 8 per cent pilocarpine every three hours at this time and Diamox is not required for the left eye.

There was no opacity of the lens in this case, but the lens was quite yellowish in color and the anterior chamber was less than 1 mm. and the corneal diameter was 8.5 mm.

Sometime in the near future another operation will have to be performed on the left eye.

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A STUDY OF WHITE MALE ALCOHOLIC PATIENTS

Admitted to Connecticut State Hospitals During Fiscal Year 1956

FLORENCE ROWE TAYLOR, *Hartford*

DURING fiscal year 1956 Connecticut state hospital admissions totaled 4,227, of whom 721 received as a primary diagnosis some form of alcoholism, i.e., acute or chronic brain syndrome associated with alcohol, or alcohol addiction. More than 60 per cent (2,558) of all admissions were patients who were admitted to a hospital for the first time for the treatment of a mental disorder. This was a 5.6 per cent increase over the number first admitted during 1955. Of the total first admissions, 440 (17.2 per cent) were alcoholic, and this increase over 1955 of 14.6 per cent was the largest for the year of any diagnostic group. The senile groups (cerebral arteriosclerosis and senile psychosis) increased 9.1 per cent, while there was a decrease in the number of schizophrenic patients for the first time in 10 years. Since 1950 first admissions for alcoholism have increased 71.8 per cent, a significant factor in the total first admission increase of 31.8 per cent for that period.

But the extent to which alcohol plays a part in the problems of our mental hospital population is not limited to patients having a primary diagnosis of alcoholism; in addition to the 721 cases so classified, there were 520 others in whom alcoholism was secondary. For example, 152 schizophrenic admissions were reported as being addicted to alcohol, and some of these patients had been previously hospitalized and diagnosed as alcoholic. Table I below lists by primary diagnosis the admissions having "alcohol addiction" as a secondary diagnosis.

TABLE I
ADMISSIONS TO CONNECTICUT STATE HOSPITALS DURING FISCAL YEAR 1956 HAVING ALCOHOL ADDICTION AS A SECONDARY DIAGNOSIS*

PRIMARY DIAGNOSIS	NUMBER ADMITTED
Acute brain syndromes.....	14
Chronic brain syndromes.....	130
—	—

The Author. *Chief, Mental Health Statistics Division, Department of Mental Health, State of Connecticut*

SUMMARY

A statistical analysis of data on Connecticut State Mental Hospital Admissions for the fiscal year 1956 reveals that the largest percentile increase of patients—usually hospitalized for short terms on a physician's thirty day certificate—was in the group whose primary diagnosis was alcoholism. In addition, many mental patients have a secondary diagnosis of "alcoholic addiction." The author challenges previous concepts regarding the socio-economic position of alcoholic patients. She reveals that hospitalized alcoholic patients do not differ significantly from those receiving clinic treatment. The author believes that upper occupational categories are usually understated.

The data on marital status are in agreement with the findings of other studies.

associated with:	
Cerebral arteriosclerosis	78
Convulsive disorder	15
Senile brain disease.....	19
Other diseases	18
Psychotic disorders	214
—	—
Involuntional psychotic reactions.....	5
Manic-depressive reactions	41
Psychotic depressive reaction.....	8
Schizophrenic reactions	152
Paranoid reactions	8
Psychoneurotic reactions	59
Personality reactions	92
Mental deficiency	6
Undiagnosed mental disorder.....	5
—	—
Total	520

*In addition to these 520 admissions, there were 721 receiving a primary diagnosis of alcoholism.

The 1,241 admissions having alcoholism as either the primary or secondary diagnosis made up 29.4 per cent of the total admissions for the year. This proportion is at a minimum, since it is almost certain that answers to the statistical item of "alcohol addiction" are not reported in all cases by the patient or his family. Nevertheless, this is too large a proportion to be disregarded, and it is hoped that these data will focus attention on one of the most important mental health problems in Connecticut—alcoholism.

I. OCCUPATIONAL STATUS

What type of alcoholic needs inpatient care in our state mental hospitals? Is he of a lower social class than the clinic patient, the private hospital patient? According to popular notion he is, and this concept is accepted by even the professional experts in the field of alcoholism. In order to investigate the extent to which these patients do or do not cut across broad socioeconomic groups, an analysis was made of patients selected from the admissions for alcoholism during the year.

A total of 544 males were selected from the 721 admissions for alcoholism. These men were under 65 years of age, white, and were discharged from the hospital after a short length of stay. In other words, they were employable white males who were

suffering from acute reactions to alcohol, a group which might be comparable to a group of clinic alcoholic patients. Results of this analysis may be compared with the study made by Straus and Bacon¹ of occupational integration in male clinic patients.

The average lengths of stay varied from hospital to hospital, as follows: Connecticut State Hospital, 21 days; Fairfield State Hospital, 20 days; Norwich State Hospital, 29 days; a combined average of 23½ days. Female admissions (12 per cent of the total), admissions of nonwhite patients (7 per cent), male admissions over 65 years and those not discharged within a 30 day period were excluded. Patients with alcoholism as a secondary diagnosis and alcoholic patients admitted to a hospital for the second or third time during the year were also excluded in order to avoid duplication of patients.

The selected patients were tabulated according to their occupations. For purposes of this study, occupation was reported as the usual occupation of the patients, i.e., the job he pursued for the longest period of his working life. Instructions to the hospital record rooms defined occupation as such, but our findings indicate that, despite these instructions, the "usual occupation" entry on the statistical admission card was in many instances the patient's latest occupation. As many of the case histories as possible were reviewed for accuracy of reporting.

TABLE II
COMPARISON OF OCCUPATIONS OF WHITE MALE STATE HOSPITAL ALCOHOLICS UNDER 65 YEARS OF AGE AND ALL EMPLOYED WHITE MALE CONNECTICUT WORKERS 20-64 YEARS

MAJOR OCCUPATION GROUP	HOSPITAL NUMBER	PATIENTS PER CENT	GENERAL
			POPULATION PER CENT *
Professional, technical and kindred workers.....	37	6.9	9.3
Farmers and farm managers.....	9	1.7	1.7
Managers, officials, and proprietors, except farm.....	23	4.3	12.3
Clerical and kindred workers.....	29	5.4	7.1
Sales workers	19	3.5	6.8
Craftsmen, foremen and kindred workers.....	120	22.2	24.7
Operative and kindred workers.....	169	31.2	24.9
Private household workers.....	1	.2	.2
Service workers, except private household.....	58	10.7	5.5
Farm laborers and foremen.....	14	2.6	1.3
Laborers, except farm and mine.....	56	10.4	5.3
Unknown	5	.9	.9
Total employed	540	100.0	100.0
Never employed	4		
Grand total	544		

*Based on occupation classification of all white Connecticut males, ages 35-54, 1950

and it was found that there was a tendency to report occupation as one of lower status than the facts warranted. Therefore, some caution must be observed in the interpretation of these findings, since it was impossible to determine the accuracy of all entries for "occupation."

The occupation code system used was that contained in the Alphabetical Index of Occupations and Industries, U. S. Department of Commerce (1950). Because the first digit of the occupation code represents broad socioeconomic groups, cards for these patients were sorted accordingly, and the results appear in Table II.

Since 68 per cent of the 544 cases under study were between 35 and 54 years of age, a further analysis was made of their occupation classification as compared with the same age groups in the general population. The differences were more significant statistically than the differences in the table above.

engineers, two physicians, two medical or dental technicians, a school teacher, two authors, a clergyman, a chemist, a pharmacist, and three lawyers. All were college educated. Other groups, such as clerical workers, showed similar proportions (5.4 per cent and 6 per cent) but direct comparisons could not be made in all cases, because of the differences in classification of occupations between the two studies.

II. MARITAL STATUS

An analysis of marital status of these patients by broad age groups reflected much the same findings as did Bacon's study of *Inebriety, Social Integration and Marriage*.²

In age groups 35 to 54 there were more than twice as many single men proportionately than there were in the male population of the State in the same age groups. In the general population, 13.2 per cent of

TABLE III
NORMAL EXPECTANCY OF OCCUPATION OF WHITE MALE STATE HOSPITAL ALCOHOLICS 35 TO 54 YEARS OF AGE*

MAJOR OCCUPATION GROUP	NUMBERS		PERCENTAGES	
	OBSERVED	EXPECTED	OBSERVED	EXPECTED
Professional, technical and kindred workers.....	26	36	7.1	9.8
Farmers and farm managers.....	8	6	2.2	1.7
Managers, officials and proprietors, except farm.....	15	57	4.1	15.5
Clerical and kindred workers.....	17	23	4.6	6.4
Sales workers	14	24	3.8	6.5
Craftsmen, foremen and kindred workers.....	78	94	21.2	25.5
Operatives and kindred workers.....	125	83	34.0	22.5
Private household workers.....	1	1	.3	.2
Service workers, except private household.....	41	20	11.2	5.6
Farm laborers and foremen.....	7	4	1.9	1.0
Laborers, except farm and mine.....	34	16	9.3	4.4
Unknown	1	3	.3	.9
Total employed	367	367	100.0	100.0

*Based on occupation classification of all white Connecticut males, ages 35-54, 1950

Both of the above tables reflect the fact that there were smaller proportions of professional, managerial, and skilled workers than would normally be expected on the basis of State statistics. There were, however, more than enough to indicate that state hospital alcoholics are not significantly different from clinic patients. The study made by Straus and Bacon¹ revealed that six per cent of the clinic patients were professional people, while 6.9 per cent of state hospital patients in this study were classified as professional or technical. This group of 37

men included five accountants and auditors, three white males 35 to 44 were single, and in the group 45 to 54, 12.5 per cent were single. The corresponding proportions for this study were 28.2 and 24.5. Also in agreement with Bacon's study² was the high proportion of divorced men, as is indicated in Table V.

III. LEGAL BASIS FOR COMMITMENT

The cases under study were further analyzed by type of commitment, and Table VI reflects the legal basis for commitment at time of admission.

TABLE IV
MARITAL STATUS OF WHITE MALE STATE HOSPITAL ALCOHOLICS
UNDER 65 YEARS, BY AGE GROUPS

MARITAL STATUS	TOTAL	AGE GROUP				
		UNDER 25	25-34	35-44	45-54	55-64
Single	151	14	28	58	40	11
Married	228	5	33	83	67	40
Widowed	25	—	—	8	8	9
Divorced	84	1	8	34	30	11
Separated	54	—	8	23	17	6
Unknown	2	—	—	—	1	1
Total	544	20	77	206	163	78
Per cent	100.0	3.7	14.1	37.9	30.0	14.3

TABLE V
NORMAL EXPECTANCY OF MARITAL STATUS OF WHITE MALE
STATE HOSPITAL ALCOHOLICS UNDER 65 YEARS

MARITAL STATUS	NUMBERS		PERCENTAGES	
	OBSERVED	EXPECTED	OBSERVED	EXPECTED
Single.....	151	163	27.8	29.9
Married (including separated).....	282	363	51.8	66.8
Widowed.....	25	10	4.6	1.9
Divorced.....	84	8	15.4	1.4
Unknown.....	2	—	.4	.0
Total.....	544	544	100.0	100.0

TABLE VI
LEGAL BASIS FOR COMMITMENT, WHITE MALE STATE
HOSPITAL ALCOHOLICS, UNDER 65 YEARS OF AGE

LEGAL BASIS	NUMBER	PER CENT
Physician's 30 day certificate.....	496	91.2
Transfer from penal institution.....	19	3.5
Police court	18	3.3
Voluntary admission	11	2.0
Total	544	100.0

Since these cases were selected on the basis of a short length of stay in the hospital, it was not unexpected that 91 per cent were in the hospital on a 30 day certificate. Patients admitted by probate or superior court commitment would have been excluded by the selection of patients who left the hospital within a 30 day period. Relatively few, however, were committed by the police court (3.3 per cent) and almost the same proportion (3.5 per cent) were transferred from penal institutions. The remaining two per cent were men who voluntarily requested admission.

CONCLUSIONS

It is likely that the number of alcoholic patients in the upper occupational categories is understated. Nevertheless, it is of some interest to know that at least 44 per cent of all male alcoholics under 65 years of age admitted to state hospitals are in such categories as professionals, managers and officials, clerical workers, sales workers and craftsmen.

As was true in similar studies, alcoholics here were found to have significantly high proportions of single men and men who had been divorced.

Small numbers of alcoholics are committed by the courts or transferred from penal institutions. Of the 721 admissions during the year for alcoholism, 69 per cent were hospitalized for a period of 30 days or less.

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THE PHYSICIAN'S ROLE IN COMMUNITY HEALTH AFFAIRS

DWIGHT H. MURRAY, M.D., *Napa, California*

The Author. *Past President, American Medical Association*

SUMMARY

Physicians have different roles. The private practitioner treats the individual in the community; the public health officer treats the community as an individual. The principal role of the physician in community health is that of a leader. For this is the public health official receives special training.

More responsibility is being placed upon the citizens in public health matters and group judgment is a necessity.

The health departments have certain functions defined by law. Included in these are the keeping of vital records, maintaining sanitation, preventing communicable diseases, maintaining the health of the child population including the school-age child, developing health education, preventing the increasing rise in accidents, furthering research in the knowledge of chronic diseases, and increasing the experience in dealing with social problems.

Close cooperation between the health officer and the practicing physician is necessary. They have the same purpose, to foster better medical care for all.

health can divide health and hospital affairs, the practicing physician cannot. The hospital is a necessary instrument in healing the individually sick, and may serve as a diagnostic center to assist the physician. The hospital, and especially the personnel connected with it, are all part of the community health team, but they are primarily in the curative phase of the work.

NEED FOR LEADERSHIP

What is the role of all physicians in community health? In one word it is leadership. The qualifications for leadership in public health rest on a basis

FOR 35 years I have been in the general practice of medicine in Napa, California. Like so many doctors my age, I have witnessed our nation's phenomenal progress in medicine, in healthful living, in freedom from illness and disease and in life expectancy.

No single group can take credit for these achievements. Each has contributed his part to the whole progress. I am proud of the "team" approach we have used in giving our country the best medical care and healthful conditions in the world.

I am proud, of course, of the contributions of my own profession. However, I am equally proud of the contributions by our hospitals and nurses, our public health agencies, our pharmaceutical industry, our dentists and others in allied fields.

So I am happy to be here to talk with you—those who already work full time for the betterment of public health and those who soon will take their places in this great work.

When I was asked to talk on "The Role of the Physician in Community Health and Hospital Affairs," two thoughts immediately came to mind. First, what kind of physician is meant? Some of us devote our time to preventing illness from reaching the body, usually through control of the environment. Others, like myself, spend it healing those already ill.

Organized medicine recognizes that, while all are doctors of medicine and the mutual goal is perfect health for all, the approach to this goal can and may be dual. It is in this sense that I refer to the different kinds of physicians. One treats the individual in the community; the other treats the community as an individual. While prevention can be applied to the community as a whole, as well as to the individual, direct therapy must be strictly personal. Therefore, both medical skills are needed.

Second, I am sure there was no intention of separating health and hospital affairs. Although public

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of medical education. True, in the modern scene merely being a doctor does not qualify an individual to be a successful public health official or leader. He needs, in addition to his basic medical training, other skills, particularly in group leadership, in administration, in handling of budgets and in the application of educational measures to the persuasion of the public toward actions beneficial to their own and to the public health.

The modern public health leader requires special training and part of his leadership has been exerted toward the procurement of that training. Paralleling the interest of the medical profession in medical education and postgraduate education, the physicians and other workers in public health have established the 11 schools of public health which now train workers for the various specialty jobs in public health.

The American Public Health Association, through its Committee on Professional Education, has set up standards of qualifications and educational requirements for physicians in various phases of public health work such as administrators, epidemiologists, and those in special fields like tuberculosis, the venereal diseases, etc., as well as for public health nurses, sanitary engineers, sanitarians, public health educators, statisticians, and other groups. Under these standards the quality of public health work has steadily advanced. There is in this field, as in many other professional fields today, a tremendous opportunity for intelligent, well trained and conscientious young people. A shortage exists and positions are plentiful. Compensation is not high and the public health worker must get a large measure of his satisfaction from the knowledge of a duty performed and a responsibility discharged to society.

Responsible public health leaders agree that in the last analysis the success of their programs depends upon the practicing physicians and other medical personnel and medical facilities in their communities. A health department, unsupported by the medical profession, divorced from the community's hospitals and alienated from others in the community working toward similar goals, is a sorry thing indeed. For that matter, any professional group which has failed to recognize its interrelationships with other professional groups is missing a large proportion of its opportunities and is falling far short of its obligations. The only solution for constructive progress in public health lies in the cordial cooperation of all groups concerned with

mutual respect for each other's principles and opinions. This implies not only agreement in the main, but it also implies the ability to disagree in certain areas without endangering the whole fabric of cooperation.

The modern trend in public health is to place more and more responsibility upon citizens. The health officer perhaps, under the law, has the most official authority in the entire governmental organization of the United States. Only he can impose a quarantine which restricts the comings and goings of people who have committed no offense. Only he can issue orders under a broad legislative delegation of powers which may seriously curtail the ordinary rights of the individual. In fact, the courts have held that as long as the health officer is fair and reasonable, there is very little limit to his authority exercised for the protection of the public health and greater good of the greater number. Yet the modern health officer, if he is wise, lays aside the cloak of authority. Where formerly he issued orders, he now endeavors to persuade. Where formerly he developed programs and tried to sell them to the community, he now calls community leaders to him and together they plan projects, blending their ideas and finally coming out with a plan which is an amalgamation of the best of all their ideas and represents no individual's pet theory. Naturally such plans, democratically arrived, command much more enthusiastic support than do the brain children of the individual, no matter how capable.

GROUP JUDGMENT NECESSARY

Group judgment does not imply lack of respect for authoritative opinion. The group needs the expert but the expert should no longer dominate. He now advises and suggests and the extent to which his advice and suggestions are followed depends upon the respect in which the group holds him professionally and as a person. This modern concept of public health is a far cry from the old idea of the health official sitting in his sanctum and deciding under the law what people ought to do and then proceeding to make them do it if he could.

The responsibilities of health departments are defined by law. The health officer, when he takes office, takes an oath to enforce the law and to do those things which are necessary for the protection and promotion of the public health. In the keeping of this oath, he deserves the support of all good citizens and especially of his colleagues in the medi-

cal profession. No one can understand so well as the doctor the requirements and the necessities of public health programs. No one can so effectively support a sound public health program as can the medical profession in the community. By the same token, no one can so effectively oppose ill considered schemes.

VITAL RECORDS

A basic public health responsibility is the keeping of the vital records of life, death, marriage, and divorce. In some communities these records are kept by the county clerk, but in some areas the health officer is also, by law, the registrar of vital statistics. This is a strategic combination of offices because the vital statistics provide the public health official with the basis for his programs.

SANITATION

A second basic responsibility is community sanitation. Changes in the pattern of living have created new sanitary problems. The great mobility of population and the development of suburban areas have brought about changes and confusions which have not existed in the more settled patterns of the past. Advances in technology have created industrial wastes with the pollution of streams and of the air. The distribution of food, the vending of food through machines and the growing habit of eating in restaurants have created new problems of food supervision and sanitation. The job of the sanitary engineer and the sanitarian in keeping our communities clean is far from "all washed up."

PREVENTION OF COMMUNICABLE DISEASE

Closely allied to sanitation in some respects is the prevention of the communicable diseases. This, too, has been accomplished in large measure by sanitary improvements but the new factors in our living patterns have rendered some of the old safeguards ineffective. We must still guard against the introduction of diseases arising out of our environment and out of the infestation by parasites. Immunization programs, which have become established as routines, may be neglected and such diseases as diphtheria creep back into the reports unless there is constant leadership and insistent pressure to keep the immunization levels high. The conquest of such diseases as polio is a continuing challenge and the encephalomyelitis diseases are a dangerous threat.

A part of the function of the modern health department is to provide laboratory facilities for the

diagnosis of the communicable diseases, for the testing of water supplies, and milk, and for the analysis of foods.

CHILD HEALTH

The health of the child population is a responsibility of the health department along with the practicing physician. In some communities the level of education is low and parents are not motivated to give their young children the necessary supervision in health which will keep them from developing preventable diseases. In such situations, health department leadership, through educational devices and through well-baby clinics, may be a function of the public health department.

HEALTH EDUCATION

Still another obligation of health departments is a broad leadership in health education assisting in orienting the populace with regard to health and disease. The health education function may require some form of demonstration as in the well-baby clinics where the chief purpose is the education of the mother in how to care for the child and how to recognize signs of impending illness plus the importance of continuous medical supervision during health.

The modern public health official feels an obligation to broaden the scope of his leadership. He sees people dying of heart disease, of cancer, of tuberculosis and of other preventable diseases. He sees them suffering from arthritis, from diabetes, high blood pressure and general lack of good health through various vague and undefined causes. He observes them succumbing to mental disease or living miserable lives, a prey to anxieties and emotional disturbances.

He does not expect to provide medical treatment for such persons, recognizing that this is the function of the practicing physician and the facilities in the community such as hospitals and rest homes and the like.

More and more of our people are living longer and longer. This is a reflection of more favorable death rates at earlier ages: the saving of infants, the greater safety of our children from the communicable diseases, the increasing safety of childbirth and the lowered morbidity and mortality from the diseases of adult life, notably pneumonia and the respiratory diseases, appendicitis, tuberculosis and practically everything else except accidents. But longevity in itself poses problems and for the solution of these

problems the health officer feels a responsibility which he shares with the medical profession and other responsible agencies in the community.

INCREASING ACCIDENT TOLL

No health officer, nor any other citizen, including the practicing physician, can look with equanimity or complacency upon the dreadful record of increasing death and injury from preventable accidents. The record in industry, which is the best of all accident records, shows what concentration and determination can do in bringing down this rate. In the home, on the farm and on the highway, the toll of accidents remains deplorable and frightening. It is a challenge to the health officer, the practicing physician and the responsible citizen. It can be dealt with only by a team approach in which all of them participate.

CHRONIC DISEASES

Among the problems which loom large, not only in the aging but in those in their prime, are the chronic diseases. Arthritis, diabetes, high blood pressure, multiple sclerosis, cerebral palsy, epilepsy and many others challenge the modern community to do something about their victims. In some cases, more research is required to unearth causes and develop better medical treatment. In others, the approach is to broader dissemination of knowledge concerning existing opportunities which are not being utilized to the full. In some, as in the case of epilepsy, the problem is medical as well as sociological.

SOCIAL PROBLEMS

Social problems which cut across health problems are poverty, ignorance, and alcoholism. For all of these the health officer, together with the practicing physician and the citizen, must feel a responsibility and they must tackle these problems in unison, in cooperation and with a mutual understanding. Only in this way can progress be expected.

HEALTH OF SCHOOL-AGED CHILD

A responsibility which the health officer shares with the schools is the protection and promotion of the health of the school-aged child. In this the schools may exercise leadership in certain communities while others may not be able to do so. In either case the public health official still has responsibilities for sanitation and communicable disease control within the schools and his authority may supercede that of the school board. In the modern

picture, however, it seldom becomes a question of authority. Cooperation is the key word. Both schools and public health officials tend more and more to leave responsibility for health examinations of school children, immunizations, correction of physical defects and the meeting of other demonstrated health needs to the family and the family physician. This is where the responsibility rightfully belongs and this is where it should ultimately come to rest.

The practicing physician, as well as the health department, has a definite field of responsibility. This is the care and treatment of the individual patient. This may and should embrace a large measure of preventive as well as therapeutic attention. The modern trend is for the immunization programs to be placed in the hands of the practicing physician and the mass clinics where thousands of children are inoculated are gradually disappearing. The school tonsillectomy is a thing of the past and school dental clinics are relatively rare. The public health official, having plenty of responsibilities of his own, is wise to stay out of the field of treatment because treatment can be rendered best only in a relationship between doctor and patient which is personal and confidential. In some instances where families are unable to provide their own, community aid may have to be provided. When this happens the relationship between doctor and patient must be respected.

The wise health official and the wise leadership in medicine in each community recognizes its own prerogatives and limitations and those of the other group. By conference and cooperation it defines areas of responsibility, eliminates duplication and overlapping, and works out a smooth program of cooperation so that each knows what his responsibilities are and each discharges them without attempting to enter the field of the other group.

HEALTH OFFICER AND PRACTISING PHYSICIAN

The health officer needs to stay close to his medical colleagues, and they need to stay close to him. In this vital relationship both have been remiss. Health officials have been prone to feel that they could go ahead alone. The medical profession on the other hand has failed to keep in touch with the progress of public health work in its own community, except when matters arose which moved them to adverse criticism or to open opposition. These differences have appeared at all levels from the local to the national. They are the more deplorable in that they are so unnecessary.

The purpose and the motivations of health officials and of practicing physicians are the same. In the preamble to the Constitution of the American Medical Association there occurs a terse statement of its aims, which are "The improvement of the science and art of medicine and the betterment of the public health." The official seal of the American Public Health Association contains a tree and the phrase, "And the leaves of the tree shall be for the healing of the nations." This is a reference to the 22nd chapter of the Book of Revelation in which the tree of life is described and it is the leaves of this tree to which the public health motto refers.

Throughout the years the most successful public

health work has been carried on where doctors and public officials worked closely in unison and in harmony. This does not preclude differences of opinion nor does it obviate disagreements. It does, however, do away with unproductive rivalries and with unseemly bickering which can do nothing except discredit both the medical profession and public health officialdom in the eyes of the public which grows more and more discriminating year by year.

We have accomplished much. There is still much to be done. May we continue to develop the cooperation between public health and the practicing physician so essential in achieving our mutual goal—better medical care for all Americans.

MILITARY SERVICE

REAR ADMIRAL B. W. HOGAN, MC, USN, *Washington, D. C.*

The Author. *Surgeon General of the U. S. Navy*

SUMMARY

Whether the medical student plans to make military medicine a career or whether he intends merely to fulfill his delegations under Selective Service, he should be familiar with certain noteworthy features found in military medicine today. The requirement for armed forces of larger size than ever before has come about through our increased international responsibilities.

The Doctor's Draft Law was enacted to care for increased medical requirements. After its expiration this year physicians will be subject to the regular Selective Service Act. Some are called to military service prior to residency training and some during or after its completion. The Armed Forces has a Reserve Medical Officer Commissioning and Residency Consideration Program known as R.C.A. This program arranges the time of commissioning for the young physicians.

The Medical Departments of the armed forces have definite objectives. Although the medical officers are allocated to different branches of medicine, the majority are assigned to clinical medicine.

There are many rewards for one engaged in military medical service. Because an insufficient number of physicians have chosen to remain in the armed forces, certain incentives have been authorized. These include more equitable promotions, increased pay, an excellent residency program, and a senior medical student program.

IT is a pleasure and an honor to take part in this symposium upon the "Economics of Medical Practice." Through the foresight of those under whose aegis these meetings are being held, you are to be exposed to information which will assist you in the near future as you encounter the realistic demands which will be made upon you as practicing physicians in a changing economy. It is a pleasure also to meet you personally and collectively as representatives of that great medical school of Yale University, which has furnished more than its quota of medical men to the ranks of men who were great. I might note here that all too often physicians in their intense devotion to the scientific aspects of their profession have neglected the social, economic, and even emotional problems which surround them on every side in medical practice. Understandable as this is, it can lead to trouble. More than half a

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century ago Oliver Wendell Holmes, while addressing the graduates of Bellevue Medical College in New York, warned them that doctors who were too busy to note and take heed of the social and economic tides which surrounded them were sometimes engulfed by these tides. If you seek an example of this, then consider the once proud and highly scientific German medicine of the early decades of this century. It was engulfed by tides and it has not yet recovered.

I note from the program that I am to speak upon the subject, "The Military Service." Inasmuch as I am the only representative of the military medical departments to appear on the program, my remarks will, in general, be applicable to all three of the military services. However, for purposes of example and specificity, I will draw on my own personal knowledge and experience as a naval medical officer. I am probably the wrong man to address you, for naval medicine has given me more than I could possibly return to it. In addition to excellent medical training and specialty board rating and the romance of medicine at sea and in far off lands, it has permitted me to work with fellow Americans under murderous enemy attack and to see my confreres die bravely in line of duty.

If you seek medicine with overtones of diplomacy, of scientific detective work, of travel and the sense of a part in history, then that is what the naval medical corps has offered me. In the students' language, it is a game of put and take; if you put little interest or enthusiasm in it, then little will be returned to you. If one enters with the attitude of the commonplace, then no rewards will be forthcoming. To invest one's self in the task entirely will result in untold rewards, tangible and intangible. You see now why I may have been a poor choice for the task before us today. The Navy has given me a great deal.

I realize that your questions will have to do with the prospect of future service in some branch of the armed forces, though I realize that some of you have already served. In my remarks I will undertake to cover specific points about the present legal obligation to serve under the Selective Service Act and the options which will be yours upon your entering upon active duty. Over and beyond this, however, I hope to make clear to you something of the professional opportunities open to a doctor in military medicine. Whether you plan for a full career in the service or whether you intend to remain in only

until your Selective Service obligation is satisfied, it is worthwhile to become familiar with certain noteworthy features that are a part of military medicine today.

Prior to World War I and II, our military establishment in peacetime was small in proportion to the vastness and size of the nation, and it was practicable to maintain both enlisted and officer strengths on a strictly voluntary basis. Our country was young and growing and it had not yet assumed the proportions of a major power. We were happy in the security provided by friendly neighbors and secure in the protection afforded by two broad oceans. We were content to let the rest of the world handle its own problems while we developed and grew, and the rest of the world was equally content to ignore the affairs of our small and distant nation, even though we might prefer to be about our advances on our own shores.

LEGAL OBLIGATIONS UNDER SELECTIVE SERVICE

Our responsibilities in the international situation existing since World War II have created a requirement for armed forces of larger size than we had ever previously maintained, except during a wartime period. While our prewar forces could be manned on a strictly voluntary basis, the greater number now required, plus the competition for trained manpower from all phases of the civilian economy, have made it necessary for the armed forces to depend upon Selective Service to supply some of the manpower needed. Prominent within this manpower need is the necessity of producing skilled physicians and surgeons. The critical requirement for medical and dental officers during the recent military episode in Korea resulted in action by the Congress to pass an amendment to the Selective Service Act to provide for the induction of doctors and dentists, even though they might be above the age limit for the general draft. This so-called "Doctor's Draft Law" set the priority in which doctors and dentists should be called, based upon length of previous service and deferment for medical education. You are probably acquainted with those provisions which gave first priority to those who had received some, or all, of their medical education as students on active duty in the Army or Navy program and had subsequently served less than 90 days. If the doctor had served over 90 days, but less than 17 to 19 months after graduation, he was classed in priority II. Those who had none of their education at government expense, but had never served, were placed

in priority III. All others (including those who had completed two years on active duty) were placed in priority IV.

The Doctor's Draft, like any emergency measure, undoubtedly discommoded a number of physicians and they frequently entered the service at great personal inconvenience and sacrifice. And yet we could not have functioned without them, for they were of inestimable value in meeting the medical demands of the Korean emergency. In addition they have helped to maintain our medical service in the years that have followed. The Doctor's Draft amendment expires on June 30 of this year. The expiration of the Doctor's Draft will then leave young physicians subject to the provisions of the regular Selective Service Act. This is the act under which you registered at age 18 and which requires of you two years of obligated service. As you are no doubt well aware, the obligation to serve is extended to age 36 for those who were deferred for educational purposes at some time between ages 18 and 26. Since few doctors complete their internships much before age 26, it is apparent that most men who have obligated service will perform it after that age. The question of the preferable time to perform obligated service is one that receives varied answers. For some it seems desirable to enter the service directly after internship, while others prefer to obtain some, or all, of their residency training first. An individual's personal situation is bound to have an important bearing on this question.

From the standpoint of the military services it is highly desirable that an adequate number of doctors complete their training in the various clinical specialties prior to entering upon active duty, but each service is also in need of a proportion of doctors in billets for which specialty training is not required. From the standpoint of civilian medicine it is not practicable to accept every intern for residency training but neither it is feasible to operate a training program without placing some of the graduating interns in residency training. Thus it appears desirable on all counts for some doctors to enter the service directly after internship and for others to receive residency training first.

THE R.C.A. PROGRAM

Having agreed on the desirability of allowing variation in the time doctors come to active duty after internship, our next problem is to decide which individuals are to report before and which ones after residency training. The approach to this decision is

through the mechanism of the R.C.A. program, or "Berry" Plan, more fully designated as the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program. The R.C.A. Program is operated by the Department of Defense, under the direction of Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical). A brochure describing this plan has been distributed to all interns throughout the country each summer for the past three years, and, undoubtedly, most of you are familiar with it.

In brief, then, the R.C.A. program provides for voluntary commissioning of doctors during internship, deferment of some of them for residency training, and a choice as to the time of reporting to active duty for those not deferred. In the current year about half of those participating in the program requested active duty during the year following internship, and the remainder requested deferment for residency training. About one fourth of the total were granted deferment for residency training, subject to obtaining approved residencies and subject to qualification for and acceptance of a commission. The number to be deferred in each specialty is determined from the projected needs of the three armed forces. When the number of applicants for deferment in a given specialty is greater than the combined triservice requirement, selection of those to be deferred is performed by "lot." When the number requesting deferment for training in a specialty is equal to or smaller than the armed forces requirements, all are selected as principals for deferment. You can understand how it comes about that in the more popular specialties, such as general surgery and internal medicine, there may be more applicants than the services need, while in other specialties, such as otolaryngology and orthopedics, there may not be sufficient applicants for deferment to meet the service's needs.

While deferments for residency training under this program can be granted for only one year at a time, it is the expressed intention of the Department of Defense to renew the deferments annually for two, three or four years, as necessary to meet the formal training requirements of the various specialty boards. Renewal of deferment is contingent upon the individual doctor's desire and upon his satisfactory progress in the institution in which he is receiving his training. This program thus assures those who are selected as principals an opportunity to complete their formal specialty training before coming to active duty.

Let us suppose that one is not selected as a principal, or if selected as a principal that one has not obtained an approved residency. Under the R.C.A. program you have the privilege of choosing the quarter of the year in which you desire to be called to active duty. Insofar as possible the military services would adhere to your desires. This is an obvious advantage as it permits better planning both for the immediate future and for resumption of training or other activities at a specified time after the completion of your obligated service. Pursuant to this feature of the plan, the Department of Defense allows the three services to exceed their allowance of medical officers, as necessary, in order to place R.C.A. participants on active duty during the three months' period of their choice.

The majority of doctors choose to report for active duty in the first quarter after internship, but some have elected the last quarter of the year following internship. Most of those who elected active duty in the fourth quarter do so in order to take a first-year residency. Those not selected as principals for deferment, however, may not be granted a reporting date later than the fourth quarter after completing internship.

Participation in the R.C.A. program is entirely voluntary. While in the program, the doctor's status with Selective Service is definitely established. With his reserve commission and participation in the R.C.A. program, he is in the clear with his draft board. If a doctor desires, prior to accepting his commission, to withdraw from the R.C.A. program, he may do so. In this case, he is returned to the control of Selective Service.

Thus far I have spoken of military medicine primarily from the standpoint of the legal obligation to serve. This obligation is naturally a matter of vital concern to each individual who is planning a career in which military service is to be only an interlude and, hence, we are justified in spending our time in this discussion.

OBJECTIVE OF MEDICAL DEPARTMENT, USN

Now, however, I am anxious to tell you a bit about the objective of the military medical departments. For this purpose, as I mentioned earlier, I shall naturally gravitate to a discussion of the one with which I am most familiar, the Medical Department of the U. S. Navy. The basic purpose of the naval medical department is to maintain the health and physical fitness of service personnel and thus to

aid in maintaining military and combat readiness. This purpose carries the implication of physical standards and preventive medicine, as well as medical care of the sick and wounded, and as you have read recently, the medical department has also responsibility for the medical care of dependents of service personnel and of retired officers and men, and their dependents. In addition, we have responsibilities in certain aspects of the medical care of civilian employees of the navy department, and for various other smaller groups. The Navy is truly a worldwide organization and the medical facilities to support its operations are necessarily far flung, with units in every corner of the globe. The average person tends to think of the Navy in terms of cruisers and battleships and perhaps you in Connecticut particularly would think of nuclear-powered submarines. However, another equally essential segment of our duties is to be found in Naval aviation, with its Fleet Air Wings and its aircraft carriers. In addition, not everyone realizes that the U. S. Marine Corps, with its land, sea and air components, is also a part of the naval establishment and, as such, receives its medical support from the medical department of the Navy. Nearly eight per cent of naval medical officers are flight surgeons, assigned to duties with Navy or Marine Corps aviation units.

The provision of medical support to the naval establishment requires a wide variety of professional skills and interests on the part of naval medical officers. Segments of the medical officer strength of the Navy must be devoted to research, pioneering in atomic medicine, special weapons; others must be devoted to aviation, diving and submarine medicine, preventive and industrial medicine, staff planning and logistics, etc. However, to accomplish the objective of providing the best possible medical care to those for whom the Navy is responsible, the vast majority of our doctors must be utilized in clinical medicine. Even in billets with primary emphasis on one of the military specialties, we cannot afford to minimize the clinical aspects of a Navy doctor's duties.

It is not a profound observation to note that a physician usually prefers, above all else, to practice his profession regardless of other responsibilities that might befall him. The ambition of every military physician is similar to that of the doctor in civilian life. He strives to become more proficient in his ability to effectively administer to the sick

and injured, and more often than not his desires lead him to seek certification as a specialist in his chosen field. In company with other men he also desires to maintain a family and a home and to raise his family in a normal and healthful environment, and this is his due. Together, these factors have combined to make every military physician prepare himself not only in his chosen clinical field, but also to some extent in all phases of military medicine. In these areas of so-called "military medicine," our sphere of influence is rapidly expanding and in the field of aviation medicine a number of definite contributions have been made as a result of projects carried on in various naval research laboratories. Aviation itself, which includes participation in antisubmarine warfare, tactical support of ground forces or amphibious landings, airlift of supplies and personnel, and the evacuation of casualties, is a major and integral part of our offensive and defensive powers. The multiplicity of these tasks and missions, along with the tremendous increases in speed and altitude and extensions of the length and duration of flights requires extensive research in the application of modern medical knowledge to select and insure competent, healthy personnel. Here is a fertile field for bright young minds. The advances in these areas, while tremendous, still leave much to be desired.

In the field of aviation medical research, the problem of adapting man to stressful environments at high speed, high altitude, intense noise, and three-dimensional space orientation continues to occupy a considerable portion of the programs of Navy, Army and Air Force. The careful selection and training of men for these stressful situations are, indeed, imperative. A complete program of research in these fields is in progress and I have no need to tell you of the importance of the answers to these questions to us. The problems of stress due to high altitude are extremely important, particularly are we interested in news of what happens at altitudes of 100,000 feet. But I do not desire to tire you with this; I enumerate these advances simply to give you a glimpse of the wonders which have opened up before us.

Research programs of great importance are going on in other fields, such as submarine medicine, preventive medicine, atomic medicine and in the broad fields of clinical medicine and surgery. Time will not permit a detailed account of these projects; however, I mention them simply for the sake of those interested in the research field and I am anxious to call attention to the vital role played by military

physicians and scientists in maintaining our national defense.

There are many more and perhaps better illustrations than those I have given to establish beyond doubt that military medicine must continue its program in an unimpeded manner. The difference between victory and defeat for our armed forces might well depend upon the ability of military medical personnel to have advance information concerning the etiology and effective therapy for certain exotic diseases in some remote geographical area. Also, if further conflict should face us and we are to repeat the remarkable medical record of World War II and the Korean conflict, our medical personnel will have to be abreast of every scientific advance and know how to utilize it in the service of our military personnel.

REWARDS OF MILITARY MEDICAL SERVICE

It should be evident from what I have said that the Navy offers much of value to the physician seeking a rich and rewarding professional experience. Had I time, I could tell you of many things and many honors for the Corps. Within the month a career officer has been elected President of the American Board of Psychiatry and Neurology. However, the course of events in recent years has tended to decrease the desire of young physicians to embark on a career in military medicine. The Korean conflict, with its attendant Doctor Draft Law, was destined to ruffle hitherto relatively smooth relationships between civilian and military medicine. Young physicians, who by no choosing of their own were subject to service in World War II and/or the Korean situation, were not disposed to remain in the service in a career status. Many physicians who were required to serve two years of military duty as a result of the Doctor Draft Law felt they were victims of discriminatory legislation and for the most part were anxious to sever connections with the military and resume practice in civil life. No one liked this situation, I assure you, the military no less than the civilians.

SOURCES OF DISSATISFACTION

Thus, in taking stock of the situation a year or so ago, we found ourselves faced with worldwide commitments involving patient care and medical logistic support for our armed forces with a numerically inadequate hard corps of medical officers to discharge these responsibilities. Whereas, up until that time we had accomplished much in making the

naval service attractive to young physicians from a professional standpoint, yet there remained a definite tendency on the part of those physicians serving their obligated service to return to civilian practice. In an all-out effort to create a setting and environment which would be highly attractive, the military sought with the aid of Congress, the AMA and other civilian medical groups to accomplish those things which would be most apt to attract and retain well motivated physicians in the military service. We began by establishing a policy of uninterrupted residency training. Since the inception of this plan, no resident whose progress was satisfactory has had his training interrupted.

Another source of dissatisfaction on the part of young doctors was the requirement for two years of sea duty. It was our opinion in the Bureau of Medicine and Surgery that there was considerable justification for reducing the time spent on sea duty. In this era of specialization, two years away from one's specialty can cause a serious loss of proficiency. Accordingly, and with excellent cooperation on the part of the Bureau of Naval Personnel, the period of sea duty was reduced from 24 months to 12 to 15 months for all medical officers except those practicing their specialty at sea, as in the case of flight surgeons.

As further evidence of good faith, the Bureau also adopted the policy of complying with requests for voluntary retirement from all medical and dental officers with twenty or more years of active service.

NEW CAREER INCENTIVE BILL

The reason most frequently quoted by physicians and dentists in the past for leaving the service has been that of inadequate pay. Of great importance, therefore, to the medical and dental corps, has been the recent enactment of Public Law 497 of the 84th Congress. This bill is known as the Medical and Dental Officers Career Incentives Bill, and was the result of the untiring efforts of the Department of Defense Task Force on Career Incentives. I might say here that I am particularly proud of the pioneer role played by the Navy Medical Department in connection with this bill. One of the purposes of the bill was to equalize promotion of medical and dental officers by giving them credit for the time spent in a medical or dental school and in medical internship, thus bringing them into lineal position with their college graduate contemporaries in the bill was to bring the pay of military medical and

dental officers in line with the pay of civilian physician or other Staff corps. Another purpose of the bill was to lessen the disparity between military pay and that of the average income of civilian physicians and dentists. The bill authorized special pay for medical and dental officers over and above their regular salary as follows: \$100 per month during the first two years of service as a medical or dental officer (exclusive of internship); \$150 per month after two years and \$200 per month after six years and \$250 per month after 10 years of service. This bill was signed by the President on April 30, 1956 and became law on May 1, 1956. I firmly believe that the passage of this important legislation is doing much to aid in restoring the prestige and pride of the physician and dentist in uniform. The favorable effects of the bill are definite and unmistakable at the present time, even though the program has been in operation only a short period. I am glad to say to you that a large number of men are now applying for admission to the Corps and the middle quarter of 1956 saw the application of 144 men for commissions.

RESIDENCY PROGRAM

Another very definite indication of the improved status for military doctors may be seen by comparing the Navy's residency training program for 1955 and 1957. During calendar year 1955 there were 204 medical officers enrolled in the Navy's residency training program. During calendar year 1957 there will be a maximum of 424 residents in our program; 46 of the latter group will be receiving their residency training in civilian institutions under Navy auspices. I might mention at this time that 15 Naval Hospitals are approved by the Council on Medical Education and Hospitals of the AMA, for the training of interns, and nine are approved for residency training. The various clinical services in our training hospitals are headed by board certified medical officers, and each program is augmented by outstanding members of the civilian medical profession who serve in a consultant capacity and assist in the development and implementation of our training programs. I am sure you will be interested in knowing something about the type of medical facilities available in the armed forces. We undertake to provide the highest possible standard of medical care to our personnel on the spot wherever they may be stationed. Obviously, however, it is not practicable to maintain full specialty coverage in every

outlying station and, therefore, provision is made for evacuation to larger centers when this appears to be in the best interest of the patient. The overall plan for medical support in the Navy provides for about 75 per cent of the medical corps to be stationed within the continental limits of the United States, with the remainder occupying billets at sea or on foreign shore. In the Navy we furnish inpatient care in 28 major hospitals—25 in this country and 3 overseas. In addition, inpatient and outpatient care is provided in 110 station hospitals and dispensaries, 75 of which are in the United States and 35 overseas. This of course, is in addition to sick bay facilities afloat which vary in accordance with the size of the ship, the larger ones possessing the supporting facilities of a small hospital. Throughout the service we undertake to provide the equipment needed for the job to be done. As a result, Navy doctors (and this is equally true in the other services) can have the advantage of practicing medicine with the best available equipment and supplies. Moreover, in the interest of providing the patient with the best possible medical care, full provision is made for such consultative assistance as may be needed both within the services and from civilian specialists. The aim of providing for the patient the full measure of care that his condition requires, appeals I am sure to every dedicated physician whose first interest is the welfare of his patient.

SENIOR MEDICAL STUDENT PROGRAM

Before I close I would like to mention the senior medical student program, which is offered by all three services and which has a significant bearing on the overall financial picture. Under this plan, selected senior students may be commissioned as Ensigns in the Navy or 2nd Lieutenant in the Army

or Air Force, and placed on active duty during their fourth scholastic year in medical school. Student who have successfully completed their second year of medical school are eligible to apply for the senior medical student program. While attending school during their senior year, they will be on active duty drawing the active duty pay and allowances of their rank, which amounts to \$338 a month without dependents, or \$355 a month with one or more dependents. Participation in this program carries with it the agreement to enter the regular service after graduation or after completing either a civilian or military internship and to serve for at least three years.

I have talked to you at length about the technical aspects of life in the Navy Medical Corps. My intent was that of exposition and explanation. What I have not been able to communicate to you is the intangible feeling of belonging to something majestic that comes with military and naval life entered upon freely. It is not definable, but it is an inevitable accompaniment of duty to one's country entered upon in good faith.

A century and a half ago a French writer spoke of Connecticut as that "little yellow spot upon the map which gives us clock makers, teachers, and Senators. The first tells the time, the second tells us how to use it, and the third makes our laws."

To this I add: It has furnished its quota of honored men to the military life and to military medicine. Some of them paid the supreme sacrifice for their country. As I wish you well and thank you for your courteous attention, I respectfully salute your colleagues and fellow alumni who have gone before you, and who have made an honorable and an enviable record.

MEDICAL ORGANIZATIONS AND THEIR RELATIONSHIPS TO PUBLIC AFFAIRS

DAVID B. ALLMAN, M.D., *Atlantic City, N. J.*

The Author, *President, American Medical Association*

SUMMARY

The work of the American Medical Association and its relation to public affairs is outlined. In doing this a brief history of the organizational structure of the AMA is furnished. Emphasis is placed on the fact that the policies of the AMA are formed and directed by the House of Delegates which is comprised of constituents of the various component societies. One of the principle problems dealt with by the AMA is national medical legislation. Other important problems are hospital-physician relations, the cost and financing of medical care, the supply of medical services and facilities, veterans' medical care, labor union relations, the improvement of physician-patient relationships, and relations of organized medicine to voluntary health organizations.

IN discussing my subject I shall confine myself to the national picture and try to describe briefly the work of the American Medical Association, with particular emphasis on its relationship to public affairs. The growth of the AMA—not merely in size of membership but more especially in the widening scope and variety of its activities—reflects the expanding role of the modern physician. That changing role was aptly described in June, 1954 by Dr. Percy E. Hopkins, a member of the AMA House of Delegates and a former president of both the Chicago and the Illinois State Medical Societies. Speaking as president-elect of the Conference of Presidents and Other Officers of State Medical Associations, Dr. Hopkins said:

"Once upon a time—in fact until fairly recently—the duties of a physician were quite simple: he took care of his patients as best he could. You will recall that the Hippocratic Oath pledged him, first, to keep the highest regard for his teacher in the art and pass on his medical knowledge to selected individuals, and second, to 'use treatment to help the sick according to my ability and judgment,' while refraining from unethical practices and maintaining due secrecy. And in another Hippocratic passage (The Art) medicine is defined as the art of 'doing away with the sufferings of the sick and lessening the violence of their disease.'

"That has been the way of it through all the twenty-five centuries since Hippocrates and his Coos School began the effort to free medicine of superstition and set it on a sound scientific course, and to establish the ethical bases which have ever since been the rule and guide of our profession. The doctor devoted himself to his patient, and that devotion has been so firmly lodged in the professional tradition that it is difficult to conceive of his spending his energies to any great extent on other activities.

"But all that has been changed. Our generation

of physicians—and probably those to come after us for a long time—have been forced out of our traditional orbits into many spheres of activity which would have been incomprehensible to our predecessors."

THE PHYSICIAN RESPONSIBILITIES

Of course, the doctor's primary duties and responsibilities actually have not changed. If he is in private practice or in hospital work, his first obligation is to his patients. If he is in public health work, his first obligation is to the health of the whole community. Regardless of the particular bent of his medical career—whether it be education, research, or administration—the physician's first responsibility is to help provide the best possible medical care and health protection for the people.

However, the point that Dr. Hopkins went on to make—and which I should like to emphasize here

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today—is that in order to carry out those primary responsibilities, physicians today must concern themselves with many things outside the purely scientific realm of examination, diagnosis, treatment and prevention. This has become necessary because of the growing complexity of the socio-economic climate in which we now practice medicine. We must keep abreast of the changes in that climate, not only in the interests of efficient medicine, but also in order to protect and preserve the fundamental traditions, ethics and principles which make good medicine possible.

The ivory tower of professional detachment is no longer tenable, or even possible, for the modern physician. His knowledge and his opinions are needed for the solution of too many problems which either affect his everyday activities, or may have a vital effect on the future of American medical practice. If the profession as a whole fails to take an active part in solving these problems, we shall be guilty of abdicating our full responsibilities as both physicians and citizens.

ASSISTANCE FROM MEDICAL ORGANIZATIONS

The individual doctor, of course, cannot take the time to learn all there is to know about health, insurance, social security, workmen's compensation laws, medical care for the indigent, veterans' medical care, hospital-physician relationships, aid to medical education, costs of medical care, governmental health programs, and the ever increasing number of legislative proposals involving medical practice. Fortunately, though, he has medical organizations which not only help to keep him abreast of scientific advances, but which also gather facts and carry out studies upon which he and his fellow physicians can base their policy decisions in the socio-economic fields. And those organizations, more and more, are adjusting and attuning their activities to the demands of the changing times.

To illustrate this on the national level, I want to outline very briefly some of the highlights in the growth and development of the American Medical Association. My purpose is not to attempt a history lecture—for I do not intend to go into that much detail—but to give you some idea of the many AMA services available to its members. These services—whether they be scientific or socio-economic, and whether they be aimed at the profession or the public—are designed, as always, to promote the art and science of medicine and the betterment of the public health.

ORGANIZATION OF THE AMA

The Association was founded in 1847 primarily to raise the standards of medical education and practice, establish a firm code of medical ethics and promote the exchange of scientific information. For the first fifty years or so it operated mainly in those general fields, and up until the turn of the century its activities were comparatively limited in relation to what they are today.

The first issue of *The Journal* came out in 1883. The first scientific exhibit, a pathology display, was presented at the AMA meeting in 1899. Four years later the scope was broadened to include all phases of medicine. Today, at a typical AMA annual meeting you can see almost 700 scientific and technical exhibits which make up just one part of a huge five-day, postgraduate course planned by the Association's Council on Scientific Assembly.

In 1904, with the establishment of the Council on Medical Education and Hospitals, the Association began the ever increasing activities which have given this country the world's highest level of medical school and hospital training. The following year brought formation of the Council on Pharmacy and Chemistry, now called the Council on Drugs, which reports to the profession on the reliability, therapeutic value and limitations of pharmaceutical products. In 1906 came the Bureau of Investigation, which collects and distributes information on quacks, cults, patent medicines and medical fads.

Health education for the public became an organized service of the Association in 1911. Later, in response to a growing demand for sound information on medical subjects, *Hygeia* (now called *Today's Health*) began publication in 1923. The Bureau of Legal Medicine and Legislation was established in 1922, and then in 1954 its work was absorbed by the newly created Law Department, which deals with a wide variety of medico-legal and legislative subjects.

To study and evaluate devices used in medicine, the AMA in 1925 set up the Council on Physical Medicine and Rehabilitation, now renamed the Council on Medical Physics. The increasing interest in nutrition and special food products led to creation of the Council on Foods and Nutrition in 1929. The Bureau of Medical Economic Research, which makes a variety of studies on the costs and distribution of medical services, began its work in 1931.

Developments in protecting the health of workers brought about establishment of the Council on In-

dustrial Health in 1938. The Council on Medical Service, organized to study the effects of social and economic changes on medical practice, was created as a standing committee of the House of Delegates in 1943. Cooperating with farm groups, communities and the medical profession in focusing attention on rural health problems is the Council on Rural Health, which began as a committee in 1945.

The next year, 1946, brought the Committee on Medical Motion Pictures, whose activities now include television and are an important part of the work carried on by the Council on Scientific Assembly. In that same year the Association established a Public Relations Department, which since then has been greatly expanded both in size and scope of operations. In 1947 the AMA created the Council on National Emergency Medical Service, now called the Council on National Defense, which deals with matters in the fields of civil defense and military medical affairs.

The rising number and variety of Congressional proposals involving medicine led in 1950 to formation of the Committee on Legislation, which works in close cooperation with the Law Department and the AMA Washington Office, already established in 1944 as a listening post and two-way information center.

As a result of the steady developments in psychiatry and the mounting national interest in the problems of mental illness, the Association in 1952 set up the Council on Mental Health. Two years later that same council established a Committee on Alcoholism to concentrate on fact finding and program development in that particular field. Still more recently, under the Council on Medical Service, the AMA created a Committee on Aging to explore a wide range of subject matter related to the health of the adult population.

So much for my capsule history of the American Medical Association. I hope that it has helped in some measure to show how the AMA is constantly expanding and adjusting its activities so as best to serve both the medical profession and the general public. Actually I have touched only a few highlights of the many services available from the permanent staff of about 650 employees in the nine-story headquarters building in Chicago.

All in all, there are more than thirty councils, bureaus and departments ready and willing to answer questions and help solve problems. Many

of them have subcommittees working in special fields. In the Division of Therapy and Research, for example, there are Committees on Research, Pesticides, Toxicology and Cosmetics, and there also are chemical, microbiologic and physical laboratories. As another example, in the socio-economic area, the Council on Medical Service has standing Committees on Indigent Care, Maternal and Child Care, Federal Medical Services, Medical and Related Facilities, Prepayment Medical and Hospital Services, Relations with Lay Sponsored Voluntary Health Plans, and Medical Care for Industrial Workers, the latter being a joint committee with the Council on Industrial Health.

I should like to emphasize that all of these activities and services, regardless of their nature, are carried out under directives and policies established by the AMA House of Delegates. AMA policy begins at the bottom with the 160,000 physician members scattered throughout the cities, towns and hamlets of the country. Their individual opinions, voiced and acted upon, determine the viewpoints of their county medical societies. Their county society delegates in turn decide the policies of the state societies. Then, the almost 200 delegates from the state and territorial societies, the government services and the AMA scientific sections, gathered together at the annual and clinical meetings of the AMA House of Delegates, determine the national policies of the medical profession.

In short, AMA policy can only be what the majority of doctors want it to be. They only have to make their opinions known on the local or county level. If the majority of American doctors agree with a certain viewpoint or policy, and if they make the effort to see that it becomes their official county and state policy, then it inevitably must become AMA policy.

While the Association's policies start at the bottom—in the "grass roots" we might say—the services start from the top and proceed in all directions, from the AMA to individual physicians, to state, territorial and county medical societies, to the general public, to allied organizations in the health field, to nonmedical groups desiring information, advice or help, to governmental agencies, to the various media of communication, to medical schools and hospitals, in fact, the list could be almost endless.

Although the past ten or twenty years have brought a great increase in the Association's informational, socio-economic and legislative activities,

there also has been a constant increase in the already predominant scientific programs. These scientific activities, including the *AMA Journal*, nine specialty journals and other scientific publications, the library, the annual and clinical meetings and medical exhibits, account for sixty per cent of the annual budget. Socio-economic and public information services take 25 per cent. Legislative activities account for only three per cent.

MEDICAL LEGISLATION

Yet an alertness to the implications of legislation involving medicine is one of the profession's greatest needs at the present time. Whether we like it or not, modern medicine has become involved in all the cross currents of public interest, public opinion and political action. In the 84th Congress, for example, 571 bills involving medicine were thrown into the hopper.

With the increasing amount of medical legislation in these times of social and economic change, medical organizations have a growing duty to study the issues, arrive at decisions and make their opinions known to both legislators and the public. Over the years many constructive proposals, actively supported by the American Medical Association, have become law, often with a minimum of argument and controversy. On the other hand, we seem to attract a lot more attention when we oppose something, such as national compulsory health insurance or last year's disability benefits amendments to the Social Security Act.

I want to emphasize that the Association's legisla-

tive policies are arrived at only after careful study based on consideration of the best interests, not only of the medical profession but of the entire American public. If and when we ever were to abandon that approach, if we were to base our policies on expediency and a fear of adverse criticism, then we would be abdicating our position of trust, responsibility and leadership in the medical affairs of the nation.

OTHER PROBLEMS

Legislation, of course, is not the only important problem demanding alertness and action. Now and in the years immediately ahead we must arrive at positive, constructive solutions to such problems as hospital-physician relations, the cost and financing of hospital and medical care, the supply of medical services and facilities, the issue of veterans' medical care, relations with labor unions, the improvement of physician-patient relationships, organized medicine's relations with voluntary health organizations, and many other problems.

To do so, medicine needs the best possible thinking and the greatest possible unity within the profession. If you already are a member of the American Medical Association, or if and when you become one, I urge you not only to take advantage of the many services available to you, but also to take an active part in helping the Association arrive at the wisest and most constructive policies. By doing so you will be not only a good physician but also a good citizen.

MEDICAL ORGANIZATION, COUNTY AND STATE

RALPH T. OGDEN, M.D., *Hartford*

AMERICAN medicine is organized politically into a democratic representative body at three different levels, county, state and national. County societies are organized by physicians within the counties. They are the grass roots of organized medicine and representatives from these associations organize the state and national societies, so that all actions taken by any of these bodies reflects the thinking of the majority of those physicians who take an active part in the county meetings. It is important, therefore, that doctors not only belong to the county associations, but that they attend their meetings, vote on the officers and committees who will transact county business, and on the physicians who will represent them at the State level.

Membership in county associations is not compulsory. Each physician who applies for membership is screened by a special committee to be certain that he is eligible by training and license, that he has other qualifications which make him a desirable associate, and that his record is a credit to him and to the medical profession.

Dues are necessary and they are compulsory. They vary with the county and depend upon the magnitude of the program and the extent of activities into which the county has entered. Some of the larger counties have extensive programs and an executive secretary may be necessary to coordinate them successfully. Under such circumstances the dues are necessarily higher than in those counties which have a small or modest program. In either case, the dues are small compared to the benefits they bring to the medical profession and to the public by maintaining good public relations and by establishing community services.

The aims and purposes of the county associations have changed somewhat since they were first organized. The original purpose was to band physicians into groups so that they could keep informed about advances in medical science, but travel and com-

The Author. *Radiologist, Hartford Hospital, Hartford, Connecticut; Past President, Connecticut State Medical Society*

SUMMARY

The organization of the county medical associations is outlined. This organizational framework is applicable to the State Medical Society. The various factors discussed are membership, dues, aims and purposes, public relations programs, grievance committees, the "Code of Ethics," official publications, legislation, health insurance plans, hospital-physician relationship, and sundry committees.

munications are now so rapid and so developed that scientific information is disseminated more promptly through such media as medical journals, medical meetings and hospital seminars. The county societies are, therefore, placing greater emphasis on programs of service and on those dealing with socio-medical and socio-economic matters.

The medical profession wants to keep the good will of the community so county associations have developed public relations programs for doing this. Some of the larger counties have developed telephone answering services and they will find a doctor for those who do not have a family physician or who cannot get one in an emergency. Some have bill collection services for collecting current and overdue accounts for their members. Some run employment agencies for medical secretaries and nurses. These and many other services are carried out by hired personnel who are especially indoctrinated so that they will perform their duties to the satisfaction of the patient and the doctor and at the same time keep the good will of the public.

Press releases, radio, and television programs are used to inform and educate the community on public health issues, socio-economics, and other medical

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matters, but of all the media used to influence good public relations, none are more effective in promoting or destroying them than the attitude which the individual physician has towards his patients. This last cannot be emphasized too much because if the personal relationship between doctor and patient is not maintained at a high level of mutual respect and confidence, other programs for maintaining good public relations will surely fail.

The medical profession is made up of physicians from all walks of life who have all kinds of personalities the same as one finds in every other profession. It is, therefore, to be expected that some of these doctors will become involved in controversy with some of their patients and with other physicians. The counties recognize this human frailty and have set up grievance committees under various names for the purpose of arbitrating such controversies. If a patient is of the opinion that he has been overcharged or mistreated by his physician, he may ask for a hearing before one of these grievance committees. The accused physician in such cases is also invited to present his side of the controversy. These committees are often able to abort legal proceedings and to settle disputes to the satisfaction of all concerned.

Every county association has a set of rules subscribed to by its members which governs their conduct with patients and with other physicians. These rules are known as a "Code of Ethics" and are what physicians consider to be a right and a wrong way of practicing medicine. Ethics is based on the precept of doing unto others as you would have them do unto you. These rules are made for what is considered to be for the best interest of the profession, the patient and the public at the time they are subscribed to. They are not necessarily irrevocable and may be altered from time to time to conform with changes in medical philosophy. Some practices which were considered unethical in past years may be accepted as ethical today and changes will be made in today's code of ethics when it is for the best interest of all concerned. Nevertheless, a code of medical ethics is necessary to guide physicians in their practices as a code of moral ethics is necessary to govern the ways of everyday life. The Code of Ethics of county societies usually parallels that of the American Medical Association and members who do not live up to it are subject to discipline and expulsion from the Society. Ethics are man-made rules and they are, therefore, subject to

criticism by others, and they are not infallible, but fortunately they can be changed when it is for the best interest of the public and the profession to do so.

Some counties publish a bulletin which contains information pertaining to matters that are of general interest to the membership. They keep the members informed about actions which have been taken by the officers and committees of the association between the regular meetings of the society. They also include news of local and national activities on all matters that affect the practice of medicine. These publications of the counties are primarily for local consumption and are only supplemental to State journals and to the *Journal of the American Medical Association*. This latter journal contains much more information on many other matters and it also publishes original articles on scientific subjects.

County and State legislative committees supplement each other in sponsoring legislation which they consider to be for the best interest of medical practice and of public health. These committees scan legislative calendars for bills proposed by others which directly or indirectly affect the practice of medicine. Those that are considered to be for the best interest of the public welfare are supported and those that are not so considered are opposed.

Health insurance plans in this country have developed rapidly in the past few years as a means for providing good medical care for everyone at a reasonable cost and they have been sponsored by the medical profession as a buffer against socialized medicine. These plans pay for hospitalization and/or medical care, either in whole or in part and they are held by a large segment of the American public. They are often referred to as Third Party Payment Plans because payment for services are made by a third party. Although some of these plans are sponsored by medical societies most of them are managed by laymen and since they pay for medical services they directly affect the practice of medicine. Consequently county and State medical societies have committees on third party payments for the purpose of studying all health plans so that the practice of medicine may not be taken over and controlled by third parties because it is still true that the one who pays the fiddler calls the tunes. It is necessary that health insurance plans be encouraged but it is also necessary that organized medicine be influential in shaping their develop-

ment along lines that will be for the best interest of the public welfare and the practice of medicine.

Hospitals are rapidly developing into health centers where people in the community can go for diagnostic procedures as well as for medical and surgical care. Hospital corporations are not privileged to practice medicine so they must engage physicians to perform these duties for them. Contractual arrangements between hospitals and physicians vary with circumstances and since some arrangements may be considered undesirable, if not unethical, committees on hospital-physician relations have been formed for the purpose of regulating the practice of medicine in hospitals so that the private practice of medicine may not be threatened and so that hospitals and physicians may not exploit one another.

There are committees on medical economics, public health, industrial health, medical education, interprofessional relations and others which are striving for better medical care for everyone at a reasonable cost, better public relations with everyone, the preservation of private practice, freedom of action for the physician in diagnosis and treatment, freedom for the patient to choose his physi-

cian and hospital, freedom of the physician to choose his patients and freedom of medical practice from control by third parties.

I would like to emphasize that regardless of whether the county program is modest or extensive its influence on the policies of State Societies and the American Medical Association is often decisive. Every eligible physician should belong to his county organization and he should take a positive part in planning its activities. He should also belong to the State Society and to the American Medical Association. Physicians who do not belong to these societies and who do not take an active part in influencing their actions have no cause to complain or to blame others for what organized medicine is doing or proposes to do.

This discussion has touched upon only a few of the activities of county and State medical associations pertaining to the economics of medical practice, and then only briefly. National health is the concern of everybody, but it should be the purpose of those who are familiar with health problems to make certain that the practice of medicine rests in the hands of those who are most qualified to preserve the present high standards of medical care.

MEDICAL ADMINISTRATION AS A CAREER

Advantages and Disadvantages

T. STEWART HAMILTON, M.D., *Hartford*

The Author, *Executive Director, Hartford Hospital, Hartford, Connecticut*

SUMMARY

The disadvantages and advantages of the medical administrator are outlined in some detail. As a career the advantages appear to outweigh the disadvantages.

may well be greater than those of a physician to the general population of the city or town where he practices. Given a good board, and most hospitals have them, the hospital administrator will have every

THE following are some of the advantages and disadvantages of a career in medical administration. The latter are noted first.

A. DISADVANTAGES

1. He is not in business for himself but is a salaried employee. As in any appointive position he proceeds more by steps than by the gradual change usual in active practice. Every physician, however, has the same opportunities to succeed or to fail. To be sure, the administrator is working for a small group who have the power to hire and to fire, but his chances of proving his worth to a small group

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chance to show his capabilities and to grow in his chosen specialty. Should he for any reason wish to move, he can usually effect a change without the financial loss entailed in relocating a practice.

2. His income is limited compared to that of a physician in some of the other specialties. This is very true, but although the peak may not be so high, it equals that of many and he probably will do at least as well in the early years. Taxes being what they are today, this is perhaps better. His income depends upon the wishes of his trustees as well as his ability; this may be a disadvantage, but there are equal disadvantages to practice.

3. He must adjust himself to the personalities of trustees, staff, personnel and patients. At times these adjustments may be very difficult, but do not all physicians have them to some degree, no matter what phase of medicine they choose?

4. He must operate a business. This is probably the greatest drawback for most physicians. Most doctors go into medicine, in part at least, because of their religio-philosophic motivations; they thus rather shun the business side of life. The administrator must operate a big business, one of the largest in his community. He must operate it as economically as possible. The multiple, complex problems of staff and personnel relations, wage schedules, purchasing, maintenance and all the others are his. To be happy in hospital administration a physician must enjoy business life to a certain extent.

5. He shares a field with laymen. There are those who might consider this a disadvantage; it is usually considered, however, that there is a place for both the lay and the medical administrator. Usually one finds the latter in the larger teaching hospital. Relationship between the two groups has always been cordial and to the mutual benefit of both.

6. He sits on the sidelines and watches the game being played. This also is one of the greatest disadvantages. The administrator must be willing to give up active, personal care of patients. He must, although using his knowledge as background, still defer to his chiefs of services in matters of medical opinion. This disadvantage is balanced to some considerable extent by the first of the advantages noted below.

B. ADVANTAGES

1. He has an instrumental share in an enterprise greater than is possible (except for rare instances)

in practice. Although he sits on the sidelines he has, throughout his career, a voice in calling the plays, in directing the progress of medicine, not only in the hospital with which he is associated but in the community as well. The course that is taken by his hospital during his directorship is in his hands to a greater degree than it is in the hands of any other staff member. What he may lose in the satisfaction of caring for the individual patient is compensated for by that of caring, although to a less intimate degree, for all who come to the hospital.

2. Community responsibilities. As director of a hospital today the physician, perhaps even as much as the public health officer, represents to his community the general field of health. He serves on committees and organizations; he speaks to groups. Since he is not in practice he can take much more active part in this phase of community life without fear of being unethical. As health has joined food, clothing and shelter to become the fourth necessity of life, so it is increasingly important that the story of health services be properly presented to an interested public. The hospital director is constantly called upon to perform this civic duty.

3. His opportunities are varied. Fields of medical administration allied to hospital administration and open to a physician in this specialty include foundations, health service plans, health and hospital consultation and certain specialized positions such as that of the Director of the Joint Commission on Accreditation of Hospitals.

4. His income is steady. Although he will never amass a fortune—and few doctors do—he is assured of a regular income, regular vacations and often the benefits of sick leave and retirement. His income is in many ways more secure than that of his fellow physicians.

5. His contacts are pleasant. In this aspect he differs little from the practicing physician. His social contacts are perhaps somewhat broader than those of his confreres in practice.

6. His hours of work are better than those of most physicians. He is better able to schedule his time and can usually expect to work a more or less regular week. Meetings, often in the evening, and on-call coverage may be somewhat confining, but these, too, usually can be scheduled. By and large the physician administrator sees more of his family than does the physician in practice.

7. He travels. Like the physician in practice the medical administrator travels to meetings and conferences. These associations serve to keep him up to date.

8. He has counsel available should he need it. The help that the administrator has available from his staff is obvious; in addition, if his board of trustees

is a broad, representative body, he can, if he chooses, call upon any of several members for assistance in problems ranging from finance through personnel to workmen's compensation insurance. He rarely needs to sail without guidance on uncharted seas. The degree to which he may do so usually depends upon the man himself.

NOTES FROM A EUROPEAN DIARY

RUSSELL V. FULDNER, M.D., *New Haven*

Continued from Page 516 (June, 1957)

Biarritz

The hotels here, several rungs up the social ladder from San Sebastian's and splendidly located on a beautiful strip of coast, are well staffed and not unduly expensive by American standards. Entering France after a stay in Spain is to be handed the key to a newly furnished city apartment after lingering in a charming, somewhat drafty castle. On crossing the border from Irun to Hendaye the sensation is as much a change in time as space, a sudden reprojec-tion into the present. Even for those not altogether sold on what the present offers there is at any rate a grateful recognition of things familiar: brightly painted homes—in wood, not stone and mortar—new cars, gasoline stations elbowing each other for room along the highway. As a further reminder of home, the attitude of the police in France struck us as abrupt and offhand. (In Spain all policemen acted like grandees and greeted the tourist as though he were a marquis at least). The French farmers looked up-to-date compared to their bandannaed Spanish confreres; tractors were at work in the fields, and on our first day in France we observed a farmer driving his cows while riding a bicycle. This struck us as a distinctive contribution to agricultural science, such as perhaps only the French would make; but afterwards we recalled that while still in Spain we took a snapshot of a drover conveying a brace of oxen with an umbrella hooked on his elbow against the event of rain. At the time this had also seemed original and progressive, and we asked whether the umbrella was for the use of the

man or the oxen. The question was plainly regarded as silly but we received, as always in Spain, a polite reply.

Lourdes; Carcassonne

Arriving in Lourdes we found the town engaged in what was evidently a universal repavement project on an all-out, let's-get-this-thing-over-with basis. It was hard to know, at times, whether the Simca was proceeding through a street or a ploughed field lately under bombardment. We were told that detours had been arranged, but the planning board unfortunately seemed not to have carried planning so far as to let anyone know their location. Settling like the curtain of night on all things, the layered dust before long began to elicit hitherto unheard sounds from the Simca's rear springs, as well as from the Simca's driver. It was at this critical juncture that we came to the *cité religieuse*.

The church grounds are picturesquely set in a sharp bend of the Pau, a briskly running trout stream, the high wooded slopes of the Pyrenees visible to the south. Gazing in the direction of the mountains a sculptured Virgin now stands in the streamside grotto where Bernadette, the miller's daughter, saw and heard the Queen of Heaven nearly a century ago. The space between stream and grotto has been levelled off, paved and partly set with benches. Worshippers sit, kneel, stand, shuffle on crutches; many are brought in wheelchairs or on litters. At the time we visited Lourdes large numbers of the blind were arriving on a special pil-

grimage from various sections of France. Led by relatives, tapping with canes, feet feeling for what eyes could not see, they marched hesitantly along the river's edge to the grotto, thence back to the great parvis in front of the church. Kneeling along three sides of an immense square, unseeing eyes lifted toward the spires before them, *les pauvres aveugles* were then blessed by a priest who, as he slowly moved along their ranks, repeatedly implored for them the gift of sight from the Almighty. . . . The night march of the pilgrims is surely one of the world's most moving spectacles. In files and by hundreds the blind and maimed move in halting and all but unending procession along a vast esplanade to the church, each individual bearing a shaded, shaking candle. Their voices, tremulous yet seeming to dare to hope, join in the recurrent litany of the *Ave Maria de Lourdes*, a supplicatory chant of great emotional power. Behind and separate from the church stands the great basilica, its soaring flèche thrusting upward into the starlit heaven as though to pierce its floor. Basilica, church, central flèche and flanking towers—all are brilliantly outlined with thousands of electric lights. With such a sight as this before their eyes, if ever the plea of *les aveugles* were to be granted, this is the place, and now the time.

The citadel of Carcassonne dates back seven centuries and more, some of its brick underpinnings still being recognizably of Visigothic origin. Travelers who like immersing themselves in medievalism—and probably many who don't care in the least for such pastimes—stay at the Hotel de la Cité, a spacious, seigniorial place within the citadel itself. Aversion to comfort and good food, as well as to knighthood, would be necessary to make you unhappy here. As for those adventurers who once may have ridden the lists with Sir Thomas Malory, stirring memories can be revived in climbing about the barbicans, keeps and towers of the ancient fortifications and wandering through the arched and cobbled alleys of the old city. One of France's proudest monuments, the citadel is carefully maintained and is in better condition now than at the time of the Revolution.

Provence

Only scattered stands of cypress challenge the strong winds that blow across the flat delta country near Arles, a region of salt lakes and dried marshland where the Rhône finds its way to the sea.

Twisted and tough, the cypresses seem to have found the secret of survival in yielding—yet firmly holding on. It is mid-April now. The sky is cold blue; in fields bordered by the cypress windbreaks bony fingers of grapevines stick through square patches of bare soil. Anyone who recalls turning the pages of a Van Gogh album must view all these landscapes as pure plagiarisms on Nature's part. (A plagiarist though, she is distracted by irrelevancies, and cannot carry her pictures off quite so well as he did). It is too early for wheat to be ripening, but the sight of these cypresses and grapevines leaves one with a certainty that, when ripe, the wheat fields try to imitate Van Gogh too, and doubtless succeed in looking like no other wheat fields in the world. . . . At Avignon we dined at the Lucullus, where the owner is the chef and the place lives up to the promise of its name. The traveler so minded, purse and patience holding out, may take a different wine at dinner here every night for the best part of a year. . . . A bloodless bull fight, Midi style, was being staged in the still-used Roman amphitheatre at Nîmes when we visited there, with dozens of amateur bullfighters all in the ring at once. Their objective was to wrest a cockade from the bull's horn. Most of the time, though, the fighters stood eyeing the bull and he stood eyeing them back. After viewing this spiritless exercise a long hour we understood why the local technique of bullfighting has not caught on elsewhere. Even the bulls must prefer the Spanish style; here they seemed bored, while in Spain it can at least be said that their interest is maintained.

On the Rhône's left bank near Tarascon stands the early medieval castle and fortress of the counts of Provence, to every appearance a place straight from the pages of Howard Pyle. The ponderous stone structure with its crenellated towers was erected around a central space which extended from ground floor to roof and was encircled by balconies on each landing. With this arrangement the troubadours, performing for the gentry seated at ground level, were provided with built-in amplification redounding to the benefit of lesser folk hanging over balustrades in the upper stories. (The traveler reconstructing history as he runs can visualize the precedent for the theatre's cheap seats being in the balcony.) From the battlements of the castle one gains a sweeping view of beautifully green country stretching away from the river on either side. Nearing its end here, the Rhône looks wider than much

of the Mississippi. Its Tarascon bridge, a bombing objective in the last war, has been rebuilt; but the nearby church of Sainte-Marthe still stands forlorn amidst rubble, without a steeple and with only half a roof. The castle served as a military prison during the eighteenth century, graffiti on its interior walls still being legible enough for tourists of the genre who kneel to copy tombstone inscriptions to enjoy:

Here is 3 Davids in one mess
Prisoners we are in distress
By the French we was caught
And to this prison we was brought.
Taken in the Zephyr Sloop of War
David Siday of London
David Haworth of Hull
David.....

Taken August 25, 1778, released November 27, 1779.

The Riviera

A stay at Cannes, it was gratifying to find, is well within the realm of possibility even for those still working on their first half-million. At the yacht basin, of course, such members of the downtrodden perforce content themselves with dinghies. In any event the waterfront promenades are free; brilliantly flowered, carefully tended, they make for charming walks in the sun. At this time of year, still mid-April, the beach is decidedly cool, too much even for the health professors whose shingles, flapping in the wind, invite humanity's fragile specimens to body building exercise on the strand. The shore lies bare of muscled and unmuscled alike.

Along the Riviera the flat surface of the Mediterranean attains an unbelievable quality—a thickness—of blue. Driving west to St. Raphael, one of the principal ports of the American landings in '44, one follows a road winding between ultramarine sea and churning white surf on one side, and high cliffs of deep red sandstone on the other, all colors of magical primacy. East of Cannes, toward Nice and Antibes, where population density increases and swish resorts occupy most of the shore, the red cliffs are mottled with the white and green of numerous villas and planted terraces. . . . We visited Monaco on the second nuptial day of Mlle. Grass Kellee, as the radio announcers called her. The cliffside-built town looked like a Dufy canvas, almost vertical in areas, bright flags and bunting streaming from every mast, pole and cornice, the harbor crowded with handsome ships (including officially delegated American and British war vessels). By far the most pretentious yacht belonged not to His Highness Prince Rainier but to Onassis, the

Greek oil millionaire. At the Casino the opulent flower beds and shrubbery are kept beautifully trimmed—an unfortunate choice of descriptive terms in this proximity—and color photographers run about in a frenzy of shutter snapping. Monaco gives the impression of an affluence beyond need of assertion, but the principality is said to be concerned with the frugality of today's tourists, discouragingly few of whom visit the Casino properly intent on winning a million francs.

Route Napoleon

Trying to make his way back to Paris with a minimum of commotion during the Hundred Days that were to end in Waterloo, Napoleon kept to little-used roads across the Alps, through Digne, Gap and Grenoble. Since the Emperor's day the French, perhaps partly because of their veneration for all things Napoleonic, have converted his route into an excellent highway. Intermittently steep, always scenic, it makes for stimulating driving. The Route starts its ascent on leaving Cannes, the mountains here confronting the sea, and continues to climb through the perfume fields of Grasse and the lavender-growing country beyond. Deeper in the mountains the road labors in high switchbacks along the sides of deep valleys that shelter vineyards and groves of walnuts and almonds; now and again it ascends to summits commanded by bold jutting of rock. . . . The Route tested the Simca's staying power even more than the climb to Granada. No doubt sensible of French traditions in general and those of Napoleon in particular, the car never showed any hesitancy or sign of fatigue. From Gap to Grenoble there is a panoramic change from the merely mountainous to the alpine, caps of cloud and snow wreathing the numerous lofty peaks. We had expected to find in Grenoble, surrounded by such grandeur and high altitude purity, something approaching the idyllic. Our disappointed gaze was instead confronted by a shabby industrial city that mutely but pointedly suggested we move along. Beyond Grenoble our way—though not Napoleon's—led through the two Departments of Savoy, green upland country abounding in farms, forests and the makings of electric power, where increasingly numerous chalets herald the traveler's approach to Switzerland.

* * * *

Geneva

After a long, vain search for a barber shop we made our way, a little apprehensively, into one of

the coeducational coiffure parlors that appear to be Geneva's only offering along this line. The arrangements turned out suitably considerate of the sensitive sex, female customers being relegated to a space in the rear. Haircut, with tip, came to a dollar. We were to find prices in Switzerland a little less, generally, than those at home, and the quality of food and service beyond criticism. (For tourists on a budget it is useful to keep in mind that the exchange rate for French francs is far better in Switzerland than in France, so that a preliminary stop in Switzerland becomes worthwhile if one's tour is to include both countries. Also, American Express offices redeem their travelers checks at face value while banks and hotels discount them.) The white buildings and ample boulevards of modern Geneva, well illuminated at night, form a clean, striking background to its beautiful lake. Less immediately captivating, but enriching with acquaintance, is the ancient section of town on the hill overlooking the south shore of the lake. The cramped and crowded streets in this quarter are lined with old book, furniture and curio shops, while automobiles, so far as they can force their way in at all, must keep to a crawl. Rambling through this old Geneva one runs into small park-like plazas or unexpected deadends where observation benches, placed under trees or on the slope of a hill, provide an approach both agreeable and inexpensive to the ataraxia sought after elsewhere in test tubes. . . . Vevey and Montreux lie at the eastern end of the lake, a few hours away from Geneva, in locations dominated by snow-capped mountains whose sides are green with spruce and fir. An hour's ride on a cog railway will take you from the warmth of a sunny spring day to the cold of deep snowy winter atop Rochers de Naye. On top there seems nothing to prevent a skier from going from Rochers de Naye clear to the horizon, which is crowded by a number of Switzerland's famous peaks.

Berne

While in the north of Switzerland German cultural traditions replace French, politically, the traveler soon learns, all Swiss think alike—in terms only of their own country. The *fondue* to which we were introduced by friends at Vevey—a dish at least convivial, everyone dipping his morsel of bread or meat in the same pot—is replaced in the north by hearty specialties such as smoked meats and sauerkraut. In Berne, the nation's capital, the practical lines of the limestone federal buildings

seem suggestive of Swiss outlook in general—sober, efficient, suspicious of frills (television has yet to make any headway in Switzerland). Berne's renowned clock tower and equally noted bears, the former newly refurbished and the latter frowsily disreputable, like caged bears everywhere, unmistakably continue to delight children of every age, including middle. . . . Interlaken, straddled by twin lakes and rimmed by mountains, enjoys the serenity of a matchless location, as testified by its multitude of first-line hotels. Snow-capped Jungfrau towers above the town, which has spread before the mountain's gaze, like tribute to a tutelary deity, an abundance of bright flower beds in an ample pleasance. Interlaken, like all that we saw of Switzerland, made one wish to linger, but our own tutelary deity, or demon, the itinerary, directed us westward again on our return to France.

* * * *

Burgundy

The French border guards at Le Locle were the only ones yet encountered in Europe to show any curiosity about our luggage. Their interest was painstakingly directed to every small, wrapped item we possessed, evidently on the premise that anyone smuggling Swiss watches would adroitly ward off suspicion by wrapping them to look as much like watches as possible. . . . Here in the east France is an area of rich farms and vineyards, well watered by the run-off from the densely wooded Jura Mountains on the Swiss frontier. Chambertin, Beaune, Pommard, Nuits St. George: the region abounds in names of sweet redolence. Pasteur was born at Dole, in one of a row of plain stone houses near the bank of the River Doubs. A humbler species of genius has also long thrived in the area—a succession of master chefs and vintners who have made Burgundy the gastronomic capital of France, hence of the world. At a place such as the Côte d'Or, in Saulieu, the ceremonies attendant upon the making of a meal are like unto operating floor preparations for a day of major surgery, the service at dinner solicitous as an old-line nurse hovering over a patient threatened with a decubitus. For a combined course in advanced dining and tourism the student can scarcely do better than to stay a few days at the Côte d'Or—the rooms are quaint, befitting an establishment where to sleep is only to prepare for tomorrow's eating—using his time between meals, if any, for excursions to the nearby Abbey of Cluny or basilica of Vezelay.

The Abbey fell a victim to the Revolution and, architecturally speaking, was guillotined; but the basilica is a justly famous church, with the cool restrained beauty of some of the early medieval structures. It is half Roman, half Gothic; in the native rock beneath its floor lies a crypt whose primitive pillars and vaults date back in part to the ninth century.

Chateau Country

In central France, on the banks of charming streams like the Loire and Cher, which have somehow kept their simplicity unravished through long centuries of domestication, the tourist comes to the castles, palaces and great houses that France numbers among her priceless treasures. Some of the chateaux date to the Middle Ages, others to the Renaissance or later; each has a story, or many stories, to tell. From the tourist's point of view the effort to communicate their stories meets with serious difficulty. Intimacy, that soul of insight, is a thing denied. Regardless of his own interests the tourist, wherever he happens to be visiting, is hurriedly shunted from one room of the chateau to the next, the guide regaling the audience with tidbits concerning the length and width of the chambers or the birth dates of their former occupants. A few dedicated souls, good guides in spite of poor pay, are met with; and it must be said of even the prosy majority that they do not exhibit indifference to their jobs. But the net result of visiting a chateau is likely to be regret at having missed so much. Possibly in recognition of inadequacies in the present approach the government has lately given a new type of presentation to a few chateaux, unhappily hitting upon a technique with strong overtones of American radio and television advertising. The chateau designated for the latest treatment is viewed at night, visitors being shepherded to some exterior vantage point. After a hushed interval in the darkness a voice, as weighted with grave portent as Michael's on Judgment Day, suddenly resounds from a loudspeaker, a glare of floodlights meanwhile exposing the building. The voice, which turns out to be recorded, recounts the history of the chateau; and whatever faults the narrative style may have, understatement is surely not among them. The floodlights fade, rekindle, pick out portions of the chateau in heightening the narrative effect. To avert tedium—some people are forever letting their thoughts wander—the voice occasionally alter-

nates with other voices, as housewives do in discussing the latest detergent on one of the morning programs. . . . The effect of all this on spectators is likely to vary inversely with their ages. For those not of the youngest generation the result may be, as it was with us, a tugging sympathy for the poverty-stricken old chateau pushed thus hard to make its living in our brash modern world.



Avranches: great victories . . .

("Du 31 juillet au 10 août 1944 réalisant la percée d'Avranches dans le vacarme de ses blindés en marche vers la victoire et la libération de la France la glorieuse armée américaine du General PATTON a franchi ce carrefour")

Brittany

After the prolonged air raids launched by the Allies on Breton cities like Lorient, Brest and St. Malo during the Occupation few structures, along the waterfronts at least, remained standing. The bombardments incidental to the Liberation added their bit to the levelling process, which finally was carried to practical completion in incendiary

fires set by the defeated Germans. Today, eleven years later, new cities stand on the cleared ruins of the old, their streets of a bountiful width unusual in France, their buildings horizontally styled in the current architectural mode. Some areas are still mid-way in reconstruction, battered churches and rubble-filled craters contrasting painfully with span-new apartment blocks, like shabby cousins attending the reunion of a prospering family. Wooden barracks left by the American army have been carefully preserved and are still in use everywhere for stores and living quarters. Chocolate-colored youngsters, not yet of adolescent age, are sometimes seen playing outside the doors. . . . Excepting her cities and the landing places in the north, Brittany, to appearance at least, seems untouched by war. The fishing boats and old wharves on the south coast are again being painted, now by a new generation of artists. In fields of oats and forage grass thatched cottages still prop their leaning sheds; and standing at crossroads are those small, curiously individual stone churches built in an age when communities were isolated—or independent—enough to be guided by their own ideas. Grandmothers proceed on the day's affairs in wooden shoes and primly starched coifs—mounted on bicycles, like as not. The great hulk of Mont-Saint-Michel was spared by universal

agreement during the war and stands, as it has for centuries, a divine guardian on the coast road to Normandy.

Normandy

Once dismally familiar in newspaper and radio headlines, nearly wiped from the map in the Allied sweep from the landing beaches during the early days of the invasion, towns such as St. Hilaire and St. Lô stand today, like their Breton counterparts, almost wholly rebuilt. The landing beaches themselves, Omaha and Utah, lie just beyond Bayeux. Farther east at Arromanches, still visible though half submerged in tidewater, are some of the immense concrete caissons employed as moles and breakwaters during the debarkations following D-Day. Along the shore a skeleton of a landing ship occasionally protrudes from the sand or surf, and the determined sightseer may pick his way through blasted German pillboxes, now only ponderous chunks of concrete overgrown with weeds. In the bright sun, the sea rolling to the feet of children squatting on the beach, the story told by these relics appears ghostly and unreal, remote in time, like the depiction of another channel invasion in Queen Mathilde's tapestry in nearby Bayeux. Then quite suddenly the road opens on a forest of crosses



St. Laurent: . . . at great price

in the American cemetery at St. Laurent. The crosses in their hundreds of rows, their shocking whiteness and newness—these bring reality swiftly, oppressively. . . . St. Laurent has been spaci-ously located on a gentle elevation overlooking the Channel, the land on each side seeming as boundless and empty as infinity itself. In achieving sadness the cemetery has taken on nothing of the dismal. It is carefully tended and succeeds in giving to them, the dead, a semblance at least of an order they must so grievously have lacked in dying.

Paris

So much pictured and painted, Paris comes as a thing familiar—to tour the city is to gain only perspective, not acquaintance. Never having seen the Eiffel Tower one has yet always known it, as one has known the Statue of Liberty or the White House. Already sized up and assimilated to a tidy niche in the mind, the Eiffel Tower proves of startling bulk when actually viewed, so massive that a good-sized restaurant can be tucked away in a small area of one of its three landings. The structure was probably spared by the steel-hungry Germans during the war only because taking it down was too complicated. Napoleon's tomb, familiar in its exterior, is a brilliantly imagined and imperially executed structure within, as acid a comment on a despot's egotism as the Great Pyramid. The sweep of the Champs Élysées, at one end the Arc de Triomphe, at the other the Obelisk, the chestnut trees in blossom along its length and the magnificent fountains sparkling at the Rond-Point—surely this is the most beautiful of all the world's urban compositions. It might be, at any rate, were it not for vast herds of automobiles which, in a ceaseless frenzy of charging and snorting, give the immense boulevard the look of a western plain in the grip of a cattle stampede. At least the cattle are

forbidden to bellow, the sounding of horns being unlawful.

Contrary to all information freely bestowed on us prior to visiting Paris, the city's price scale was generally lower than that of New York.* A seat at the Folies Bergères, of a proximity to suit the most myopic, comes to less than the price of a Broadway musical, perhaps owing to substantial wardrobe savings. Every tourist dines at least once at the Tour d'Argent, and at half what it would cost him in an establishment of comparable elegance at home. Anyway, the best things in Paris are free, or nearly so: the Louvre, a bench in the gardens of Notre Dame, a walk alone the Seine, café-sitting in the University quarter or wherever you choose—the choices are infinite. Chartres, Fontainebleau, Versailles, all are within easy reach of excursion bus. It seems that Paris, like most things we value highly, consists principally of an exaltation of the mind, a state to be sure not altogether unrelated to getting rid of one's money. But as thousands of practical Parisians demonstrate, sitting in the Luxembourg Gardens on a pleasant Sunday, delighted with themselves, their children and surroundings, the exaltation can be had free of charge.

So far as the Simca was concerned Paris marked the end of the road. The trip had been 5,000 miles in length, few if any of its stretches tedious. But long journeys, whatever the road's diversions, inevitably wind up in weariness and a longing for home. . . . We returned the Simca whence it came, and with some tenderness bade it farewell. Muted in the city of its provenance, it dared not reply.

*Since this was written a substantial increase in hotel rates has been authorized by the French Government and food prices in Paris have gone up.

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EDITORIALS

Aids in Preparing for Medical Practice

The Connecticut State Medical Society and several members and friends have contributed valuable ideas and time to an experiment in one feature of the preparation of students for meeting opportunities and responsibilities in medical practice. This was undertaken with full knowledge of the many things to motivate and to try to attract student attention, including passing National Boards, completing a thesis, obtaining the latest on a clinical procedure, among others.

The setting was a lecture and discussion course of 18 sessions dealing with the Economics of Medical Practice. This was arranged and presented by the Society and the Yale University Department of Public Health in Brady Auditorium during the Fall and Winter of both 1955 and 1956. House officers and physicians associated with the several community hospitals of the New Haven area were invited also, but few attended except for one evening session on the role of the general practitioner today and tomorrow. If and when future sessions are planned, consideration might be given to early evening dinner sessions in the quarters—so attractive and comfortable—of the new Harkness Dormitory.

These sessions were designed to provide students with practical information concerning changing conditions and useful resources in medical practice. They were elective in order to give timely information for those who desired to come, and not required to pass a professor's course nor to prime a student for passing national or state examinations.

The lectures and presentations gave a rare opportunity for students and physicians to be brought up to date and to obtain "painlessly" information badly needed by so many. They gave the students useful concepts and information about the world in which they live. These concepts are so essential in these days of emphasis on people and their attitudes, on whole families, on a rapidly growing and mobile and aging population which continues with a high birth rate and a high proportion of women at work, with problems of metropolitanism and suburbanism, and questions of how to get started and where, of a career in what specialty, and when, and why, of third party payments for medical and hospital services and home care, of professional liability, and of community and medical organizations.

Dr. Creighton Barker and the staff members of the State Medical Society deserve much credit and appreciation from all concerned along with the able leaders in the different specialties who serve Connecticut patients so well, and our other helpful participants representing industry, insurance, law, military service, and the American Medical Association.

Malignant Glaucoma

Glaucoma is mentioned only too rarely in general medical journals and is not brought to the attention of the physician as often as it should be. This is unfortunate since it is a cause of much of our blindness. Much of this is preventable by treatment, either medical, surgical or both. The most frequent

reasons for poor results are failure to recognize the disease early or improper treatment after the diagnosis has been made. The question of improper treatment often follows a failure to consider all the aspects of the lesion and the failure to keep all the possibilities in mind.

Dr. Birge, in his article in this issue, deals with one of the most serious of the complications of glaucoma. Malignant glaucoma is the lesion in which the glaucoma progresses rapidly following glaucoma surgery. The problem has been difficult because the etiology is unknown. Various theories have been propounded concerning the cause. Dr. Birge introduces the concept that the size of the lens in proportion to other factors has an important bearing on the development of malignant glaucoma. He points out the fact that the ophthalmologist must constantly remember that there is such a complication and that, if the likelihood of its occurrence is considered and looked for, many an eye can be saved that might otherwise be doomed. He gives in detail the diagnostic points that should create suspicions of this lesion, the treatment that he prefers and case reports to illustrate.

The Alcoholic Patient

In large part, the relation between alcoholics and mental disorders has been ignored both by laymen and medical personnel. The alcoholic has been typified—if not caricatured—by folklore, in temperance tracts, and (save the mark) by medicine. He has been treated or mistreated as a clown or a disgrace, as a maladjusted or quasi-maladjusted individual, as an asocial or antisocial individual, or simply as a physical or moral wreck. It has been ignored or forgotten or not brought to our attention that the alcoholic is found in large numbers among the mentally ill. The recognition of the alcoholic as a patient—as a mental patient in many cases—is long overdue. The clinical separation of fact from fiction, and the cold statistical classification of hospitalized alcoholics, should extend our knowledge of the social problem, and reorient our thinking in regard to this relatively common medical problem.

A substantial proportion of the total number of all admissions to Connecticut State Hospitals is alcoholic patients. As the author points out, this group accounts for 17.2 per cent of all first admissions. In addition, many patients classified under another mental disorder rubric have secondary symptoms of

alcoholism. The article itself presents striking data on the extent of this mental illness. It may be relative to our discussion to make note of the tremendous monetary cost of caring for the alcoholic patient. The tabulation of the submitted data for the fiscal year ending June 30, 1956 showed that there were 360 alcoholic patients in residence. During the year, 812 alcoholic patients were discharged from the three hospitals. The number of days spent in the hospitals from July 1, 1955 to June 30, 1956, by all discharged patients categorized as alcoholic, totaled 63,847.

During fiscal year 1956 the average cost per day to maintain a hospital patient was \$4.80, including food, the services of psychiatrists and other professional personnel, and attendants, as well as hospital maintenance. At the rate of \$4.80 per day for each patient, the cost of hospitalization for 360 alcoholics who were in the institutions on June 30, 1956, was \$1,728 for that one day. Assuming that June 30 was an average day, the estimated cost of maintaining the alcoholic population in resident at Connecticut State Hospitals is \$630,720 per year.

The alcoholic—whether mental hospital or private practitioner patient, or neighbor—may be, as Mrs. Taylor's closing statement points up, "not significantly different from clinic patients," or from those who are met over a cocktail. The author's findings bring to light new knowledge which hitherto has been ignored or buried in reports.

State Cancer Society News

Ralph E. Kendall of Hartford was moderator of one of the key panels at the recent annual Region I session at Portsmouth, N. H.

The new physician district presidents are Henry M. Young, New Britain and John McL. Morris, New Haven. Middletown District reelected Joseph C. Woodward.

At the close of the Connecticut Cancer Drive on June 7 the \$586,200 goal had been passed by a margin of \$5,693. On that date 13 districts and 103 towns had surpassed their quotas. The State Chairman, Russell Stumpf, said that he had "never been engaged in any effort that contained more enthusiasm, more willingness to 'pitch in,' more self sacrifice."

PROGRESS IN CLINICAL MEDICINE

THE CHANGING PICTURE OF PULMONARY SURGERY

JULIAN JOHNSON, M.D., *Philadelphia, Pennsylvania*

LESS than twenty-five years have passed since Graham performed the first successful total pneumonectomy. Previous to that time, thoracic surgery was confined mostly to the problems of infection. The surgeon with an interest in the chest was involved with the drainage of abscesses either in the lung or pleura or with the collapse treatment of tuberculosis. Following the initial success with pulmonary resection, great advances were made in the technical details of the surgical procedures and in the understanding of the physiologic problems involved in the management of the patient during and after an open thoracotomy. Since that time, however, there has been a great change in the whole aspect of pulmonary surgery, especially as it relates to pulmonary infection. The advent of chemotherapeutic and antibiotic agents has been the greatest single factor in this change.

LUNG ABSCESS

Twenty-five years ago the patient who was so unfortunate as to develop a lung abscess was a very unfortunate person indeed. The putrid lung abscess and resultant mixed infection caused a profuse fetid sputum with fever and weight loss, with frequent spreading infection and death. When the cavity became well localized the surgeon was often called upon to institute open drainage but this was most often after three or more months of febrile illness. Following open drainage, the mortality was 25 per cent or more due to spreading infection. This mortality was reduced considerably by early open drainage. In the best of hands a mortality as low as five per cent was reported but this was by no means the experience throughout the country at large.

Following the introduction of antibiotics, the open drainage of a lung abscess has almost completely disappeared. Most lung abscesses go on to com-

The Author, *Professor of Surgery, School of Medicine and Graduate School of Medicine, University of Pennsylvania*

SUMMARY

The change in pulmonary surgery which has been brought about by the advent of chemotherapeutic and antibiotic agents has been a profound one. The incidence of empyema has been greatly reduced and even when it does occur, it seldom requires surgery except in infancy. The incidence of lung abscess has closely approached a diminishing point and the indications for surgical intervention have become few, usually that of resection of a residual cavity. The incidence of bronchiectasis has also been greatly decreased. The morbidity following resection has been reduced and the necessity of surgery in extensive disease has been reduced by the ability to maintain these people relatively free of infection.

By means of antimicrobial therapy, the patient with tuberculosis has a far greater chance of medical cure than ever before and if surgery does become necessary, it is likely to be for the excision of residual disease, at a time when the patient is well and no longer has a positive sputum.

The role of pulmonary surgery in carcinoma of the lung has changed very little since the modern technics have been perfected. The value of increasing the scope of the resection has not been completely demonstrated beyond that of pneumoectomy as practiced for many years. It seems highly probable that the most important thing as far as the prognosis is concerned in a patient who has undergone pulmonary resection for carcinoma of the lung is the presence or absence of blood vessel invasion in the tumor and therefore the presence or absence of distant metastasis.

Presented at the annual meeting of the Connecticut State Medical Society, East Hartford, Connecticut, May 2, 1957

August, 1957

plete healing. When the lung abscess is not completely healed, there may be a residual granulating cavity with a thick wall which may require pulmonary resection but even this has become uncommon in more recent years, for not only has the treatment of a lung abscess changed remarkably but also, no doubt, the incidence of lung abscess has also greatly changed. In our experience lung abscesses have been seen in recent years either in the elderly, in derelicts or in infants. The most frequently seen acute lung abscess is the staphylococcal abscess seen during infancy and this seldom, if ever, calls for surgical drainage unless the abscess ruptures into the free pleural space.

BRONCHIECTASIS

The early thoracic surgeons gained a great deal of their experience in pulmonary resection while operating upon patients with bronchiectasis. The disease was relatively common and there was a great backlog of patients with the disease. It was primarily for this disease that the precise technics for lobectomy and segmental resection were developed. Once these technics were developed by Alexander, Churchill and others, the mortality for resection in this disease was low.

Although mortality was avoided in the period before antibiotics, the morbidity was greater due to infection and this has been greatly reduced in recent years. Moreover, the incidence of bronchiectasis has undoubtedly been reduced due to the free use of antibiotics in the presence of pulmonary infection in infancy and childhood. Once the most common indications for thoracotomy on the surgical ward, it has now dropped far down the list.

EMPHYEMA

A patient with a draining empyema was once a very common sight on the general surgical wards in the hospitals throughout the country. This is no longer the case. The incidence of empyema has been greatly reduced by antibiotic treatment of pulmonary infections and indeed when an empyema does occur due to a delay in diagnosis, the empyema can almost always be cured without surgical intervention by aspiration of the fluid and injection of an appropriate antibiotic. In patients with loculation of the empyema or considerable clotting of the exudate, streptokinase or streptodornase have been of great assistance.

The most common type of empyema which still requires surgical treatment is that of the staphylo-

coccal empyema in infancy. This empyema usually comes on following an acute pneumonitis or small abscesses which perforate into the pleura, giving multiple air and fluid levels with a pyopneumothorax. The prompt insertion of catheter drainage in one or more locations with continued suction, in conjunction with appropriate antibiotic therapy, will give a low mortality in this group of patients.

TUBERCULOSIS

Perhaps the greatest change in the last few years in pulmonary surgery is that which has occurred in the treatment of tuberculosis. Twenty or twenty-five years ago the surgical treatment of tuberculosis was confined almost entirely to that of collapse therapy. Pneumothorax was the treatment of choice and when that was impossible, a thoracoplasty was carried out. In a few instances an extrapleural pneumothorax was used and over a period of years various types of foreign material were used in plombage to obtain collapse without the repeated necessity of inserting air in the extrapleural space. Even in that day, however, the idea of excisional therapy for disease was much more appealing to the surgeon than collapse therapy. Efforts at excision therapy, however, were not encouraging because of the continued activity of the disease and the inability to completely remove the disease. Even after the technics had been developed for resectional therapy and were being applied successfully for bronchiectasis, lung abscesses and the like, the results in tuberculosis were still dismal because tuberculosis is a widespread disease and the danger of getting bronchial fistulae with a tuberculous empyema following resection was great.

Since the advent of antimicrobial agents, the entire picture in the surgical treatment of tuberculosis has changed. Pneumothorax is seldom used any more and compression therapy of any kind is reserved for the unusual patient. In the ordinary patient with tuberculosis, the antimicrobial agents will convert the sputum to negative and, unless the disease was extensive to begin with, will allow a medical cure. If the disease was too extensive, then the patient may be left with a residual cavity but with a negative sputum, or he may be left with a caseous filled nodule in the area of the previous disease. The surgical approach to these lesions is that of pulmonary resection for the residual cavity and in many quarters this is also carried out for residual nodularity representing caseous filled nodules in the lung. At the present time I believe there are few phthisiolo-

gists who would not recommend pulmonary resection in the presence of a persistent cavity even though the sputum was negative. The problem often arises as to the ability to demonstrate a persistent cavity and to distinguish it from emphysematous blebs. Some surgeons have taken the point of view that if there is any real doubt as to the presence of a persistent cavity, the patient should be operated upon. I have been more inclined to take the more conservative approach, that unless the cavity is clearly demonstrable, the patient should not be operated upon in the presence of negative smears and cultures.

There is less unanimity of opinion regarding the persistent nodule in the lung. Until a few years ago, when a patient started out with cavitary disease and this gradually reduced in size until it filled in and remained as a nodule in the lung, the patient was considered as cured. It then became apparent that a certain percentage of these patients discharged from a sanatorium as cured would have recurrence of the disease, and it was suggested that such nodules be removed for fear of breakdown and dissemination of the disease through the lung. There has never been any unanimity of opinion as to how large such a nodule should be before it should be removed and many phthisiologists have based their opinions as to the necessity for removal not only upon the remaining nodule but the extent of the disease in the beginning. In most instances, I believe that a good many surgeons have removed such nodules by segmental resection but others have simply removed the nodule itself, a procedure referred to as nodulectomy. It is too early to say whether this practice is going to be continued. There are some recent data which suggest that recurrence of active tuberculosis is not materially different between those patients who are subjected to resection of the residual disease and those left alone. It has been suggested at a recent national meeting that it is too late to set up a really controlled experiment of treating one patient with resection and the next patient without, inasmuch as most phthisiologists have made up their minds one way or the other as to which should be done and therefore are not willing to use alternate cases for such a study. It seems likely, however, that within the next few years this practice will continue because it has been worthwhile or will be discontinued because its virtues have not been proven. Certainly there can be no doubt that there are many patients who have been

discharged as cured under these circumstances and have gone on to live normal useful lives thereafter, without the necessity of a surgical procedure. The final conclusion must be based primarily upon a statistical study. Perhaps the thing which has made a great many of us back away from the routine resection of residual lesions has been the fact that so many patients have done so well without it and because we have been hesitant to subject patients with bilateral residues to a bilateral surgical procedure, and they seem to have gotten along just as well as those who had disease only on one side and were subjected to resection.

Perhaps the greatest problem that comes to the thoracic surgeon aside from severe bilateral disease is that of tuberculous empyema. In previous years it has carried a high mortality. It was one of the chief drawbacks in instituting pneumothorax and the surgeon had very little to offer aside from thoracoplasty and drainage in the event of secondary infection. Since the advent of antimicrobial agents, it has been possible to sterilize the tuberculous empyema cavity in a good many patients. If the disease in the underlying lung has been adequately controlled, it is now possible to do a decortication on such a patient, removing the fibroid exudate and re-expanding the lung to fill the pleural space. This was previously pretty much out of the question because of the continued activity of the disease and the almost certain secondary tuberculous infection in the wound. In the patient with more extensive disease in whom the disease in the lung has not been entirely controlled, it is possible to do an extrapleural pneumonectomy, removing the tuberculous empyema along with it, with reasonably good results in some patients. It has been our experience that if the empyema cavity goes down to the diaphragm, it is almost impossible to remove it without breaking into it so that there will be a secondary tuberculous infection unless it has been sterilized previously by antimicrobial agents. Even so, in properly selected patients, a great deal may be gained by the radical approach to this type of problem. In general, however, it is much safer to sterilize the cavity before attempting any surgical procedure.

There can be no doubt that the surgical treatment of tuberculosis has been tremendously affected by the use of antimicrobial agents, just as the medical treatment of the disease has been affected also. Whether the tremendous surge toward pulmonary resection for this disease will continue or whether

it will become totally unnecessary as further agents are utilized, time alone will tell.

TUMORS

Since the original technics for pulmonary resection were perfected, there has been very little change in the surgical treatment of carcinoma of the lung and allied tumors. We are still in the unfortunate position of having no way of curing a patient with carcinoma of the lung aside from its surgical extirpation. On the other hand, it has been amply demonstrated that if it is possible to remove the lung at a time when the tumor has not progressed beyond the confines of the lung, it is possible to cure the patient with carcinoma of the lung. It has been generally felt that the presence of lymph node metastasis in the hilar and mediastinal nodes is a very bad prognostic sign, although it has also been widely recognized that the type of tumor greatly influences the prognosis. In an effort to get around the tumor which had already gone beyond the confines of the lung, the surgeon over a period of years has become more and more radical in his extirpation so that in some quarters a procedure termed radical pneumonectomy is now advised. In this procedure the surgical dissection starts at the apex of the mediastinum and the mediastinal pleura and pericardium are entirely removed along with all available mediastinal structures that may be sacrificed. The pulmonary artery and veins are ligated inside the pericardial sac and the large mass of mediastinum is removed along with the lung. In a recent report, it has been shown that by utilizing this type of radical pneumonectomy, a five year survival rate of 27 per cent was obtained, whereas it was 25 per cent before this type of procedure was employed. This would hardly seem to be statistically significant. Certain it is that this more extensive procedure has not had a profound effect upon the five year survival rate. We have recently become interested in why it is that some patients do have a cure and some patients do not. For many years it has been assumed that the patient with a small tumor, particularly if it can be picked up on the basis of a routine chest x-ray, would be conducive to a cure if it were removed. For this reason the American Cancer Society and others have advocated widespread use of routine chest x-rays in the hope of picking up early lesions and therefore providing a cure following resection. I think that almost every surgeon would agree that the highest percentage of cures has occurred in patients who had small lesions. On

the other hand, every surgeon can remember individual patients who had perfectly massive lesions in whom he has obtained a five year cure, somewhat to his astonishment. It has been the experience of all surgeons that the anaplastic type, undifferentiated tumor has a poor prognosis, whereas the carcinoid adenoma in most instances has a good prognosis. The pathologists have made an effort to classify the tumors which occur between these two types as to the severity of their malignancy. There are many who feel that if the tumor shows low grade malignancy, the patient has a good prognosis and, if the tumor shows high grade malignancy, the patient has a poor prognosis. Unfortunately, it has frequently been difficult to get the pathologists to agree as to the grade of the tumor.

Recently Dr. Fred Collier, one of our pathologists, has become interested in the problem of blood vessel invasion in carcinoma of the lung and his data would indicate that this is a much more reliable point in prognostication than anything previously available. The presence or absence of blood vessel invasion shows some correlation with the grading of the severity of the malignancy of the tumor but this is not complete correlation by any means. It is our belief that the presence or absence of blood vessel invasion is more readily picked up by different pathologists and that the unanimity of opinion regarding it is much greater than that concerning grading of various tumors. In a recent series of 226 resected specimens of carcinoma of the lung, the pathologists have found blood vessel invasion to be present in 71 per cent. The difference in these two groups as to prognosis is very striking. The five year survival rate in patients with blood vessel invasion was only six per cent, whereas the five year survival rate among the patients without blood vessel invasion was 75 per cent. This then is a much more prognostic point than the presence or absence of lymph node invasion. In the overall group, if there was lymph node invasion, the five year survival was 17 per cent, whereas without lymph node invasion, the five year survival was only 39 per cent. In like manner, in the group with blood vessel invasion, the five year survival was not affected in any manner by the presence or absence of lymph node invasion. On the other hand, in the absence of blood vessel invasion the prognosis was affected by lymph node invasion. Nevertheless, in the absence of blood vessel invasion, there was a 50 per cent five year survival even in the presence of lymph node invasion, as opposed to 83 per cent survival if there

was no lymph node invasion. It would seem quite obvious from these data, therefore, that a radical pneumonectomy is a fruitless exercise in the patient who does have blood vessel invasion but it might very well be helpful in the occasional patient who does not have blood vessel invasion but does have lymph node invasion, with the thought of perhaps removing the last lymph node involved.

While these observations certainly do not affect the present practice of attempting to bring the patient with carcinoma of the lung to operation as soon as possible, nevertheless it does explain to a considerable degree why it is that a patient may have a tumor for a long time and still obtain a five year survival following its resection, whereas another patient may have a very small tumor, apparently picked up early, and yet die shortly after his resection from widespread metastasis. As distasteful as the whole idea is, therefore, it would seem very

probable that the most important thing regarding the prognosis for a patient with carcinoma of the lung is the type of tumor he has: that is, the presence or absence of blood vessel invasion, rather than the extensiveness of the operative procedure carried out upon him. It should be pointed out, however, that we at the present time do not know whether the tumors which have blood vessel invasion have it from the start or whether they started out as small tumors without blood vessel invasion, only to change. We do know, however, that we have seen small tumors with blood vessel invasion and large tumors without blood vessel invasion. There can be no doubt that this whole problem has a profound effect upon the results of pulmonary resection for carcinoma of the lung. Whether this information can in any way be utilized to advantage in our further treatment of this disease is certainly questionable at this time.

WHAT IS THE DIFFERENCE BETWEEN THE WORLD MEDICAL ASSOCIATION AND THE WORLD HEALTH ORGANIZATION?

The World Medical Association

1. WMA is an organization of national medical associations. The unit of membership is the medical association. It is completely nongovernmental. It is not part of the U.N. It is a private organization.
2. WMA represents the practicing profession.
3. It was organized in 1947 by AMA representatives and Western European medical leaders. Purpose was to exchange knowledge on medical education and protect freedom of medicine.
4. Each member association sends two delegates, two alternate delegates and observers to the General Assemblies.
5. The executive body is the Council. This meets twice a year—has 11 members elected from the assembly and the President, President Elect and Treasurer.
6. WMA is supported by members' dues and contributions and the annual budget is about \$165,000.

The World Health Organization

1. WHO is an intergovernmental health agency. Unit of membership—member governments of U.N. and nonmember governments of the U.N. that accept the nine principles upon which WHO is founded.
2. WHO represents governments in medicine.
3. WHO is the result of proposal of U.N. in 1945 to create a specialized agency to deal with all matters related to health.
4. Each member government sends three delegates chosen preferably from the national health administration of the government.
5. The executive board is the executive body and consists of 18 members elected to represent 18 member governments.
6. Supported by dues allocated by the U.N. scale and the budget for 1958 was \$13,000,000.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

COUNCIL MEETING

Thursday, June 20, 1957 — 3:30 P. M.

160 St. Ronan Street, New Haven, Connecticut

The monthly meeting of the Council was held at the offices of the Society on June 20, 1957 and was called to order by the Chairman, Dr. Gallivan, at 3:30 P. M. There were present in addition to the Chairman, Drs. Russell, Barker, Weld, Gibson, Ogden, Fincke, Clarke, Ursone, Buckley, Otis, Archambault, Schiavetti, Gens, Seigle, Meyers, Dwyer, and Gilman. Absent were Drs. Walker, Johnson, Danaher, Feeney, Ottenheimer, Gardner, Starr and Thayer.

It was voted to add \$36.02 to the appropriation of \$350 made on December 20, 1956 to finance the referendum on social security, making a total of \$386.02.

The Secretary explained the expiration of the Doctors Draft Law and the closing of the office of the Connecticut State Advisory Committee which had been in the offices of the Society since 1950 and the termination of employment of the federally employed secretary to the Committee.

An additional allotment of \$2,000 was voted to the secretary's office for the purpose of employing an additional clerk-typist and the purchase of a typewriter and other equipment necessary for her use.

It was voted to appropriate from the general funds a sum sufficient (\$259) to install a door between rooms No. 27 and No. 28, which are to be occupied by the Connecticut Medical Examining Board after July 1 when room No. 28 is vacated by the Connecticut Advisory Committee to the Selective Service.

(a) Acting upon nominations received from the Councilors from each County, the following were

appointed members of the Casualty Planning Committee to cooperate with the State Office of Civil Defense: William R. Maniatis, Bridgeport; Reginald C. Edson, Newington, Chairman; Francis Gallo, Winsted; Mario L. Palmieri, Middletown; Luca E. H. Celentano, New Haven; Nicholas T. Phillips, Norwich; John F. Hughes, Somers; and James W. Major, Willimantic; from State Blood Bank, Victor G. H. Wallace.

(b) Luca E. H. Celentano, New Haven, was appointed the Society's representative on the Health Services Advisory Council of the Office of Civil Defense.

Acting under Article X, Sec. 3, Par. 11 of the By-Laws of the Society as amended by the House of Delegates on April 30, 1957, the newly constituted Cancer Coordinating Committee and its Executive Committee were appointed as follows:

CANCER COORDINATING COMMITTEE

William A. Geer, Bridgeport Hospital; Isaac Horowitz, Park City Hospital; Joseph A. Chiota, St. Vincent's Hospital; A. W. Ciccarelli, Bristol Hospital; William Stahl, Danbury; N. K. Mottet, Griffin; Tibor deCholnoky, Greenwich; Ronald Beckett, Hartford; Perry Hough, McCook Memorial; I. Rothstein, Mount Sinai; John E. Thayer, St. Francis; Lane Giddings, Manchester Memorial; Alfred St. James, Meriden; Vincent J. Vinci, Middlesex Memorial; G. Parrella, Milford; Paul D. Rosahn, New Britain General; Mark A. Hayes and William Mendelsohn, Grace-New Haven Community; Wayne P. Whitcomb, St. Raphael; Malcolm M. Ellison, Lawrence & Memorial Associates; Louis G. Simon, Norwalk; John G. Raymer, W. W.

Backus; G. M. Chartier, Day Kimball; J. Forbes Rogers, Stamford; William F. Stankard, St. Joseph's; Lincoln Oppen, Charlotte Hungerford; Joseph A. Reynolds, St. Mary's; E. H. Kirschbaum, Waterbury; E. J. Ottenheimer, Windham; James T. Smith, Litchfield County; Allan J. Ryan, Meriden, Chairman.

EXECUTIVE COMMITTEE OF THE CANCER
COORDINATING COMMITTEE

Allan J. Ryan, Chairman; Mathew H. Griswold, representing the State Department of Health; Edward J. Ottenheimer as president of Connecticut Cancer Society, and Drs. Mark A. Hayes, Perry T. Hough, Vincent J. Vinci, Malcolm M. Ellison, William A. Geer, William Mendelsohn.

It was voted that the Semi-Annual Meeting of the House of Delegates should be held at the Hotel Statler, Hartford, on December 11, 1957 during the Clinical Congress and that arrangements be made for a dinner that evening following the meeting to which all members of the Society and their guests should be invited and an appropriate after-dinner program be arranged. It was emphasized that this program should not be a single speaker but rather a round table discussion.

It was voted to grant the request of the Connecticut Regional Blood Bank and the Society's Committee on the State Blood Bank for permission to distribute a letter to the physicians of Connecticut. The expenses of this mailing to be borne by the Connecticut Regional Blood Bank.

The following resolution received from the Connecticut Society of Pathologists relating to payment of pathologists under the Dependents' Medical Care Act was discussed:

"Whereas, the Medical Society of the State of Connecticut has declared that the practice of Pathology is the practice of medicine, and

"Whereas, such pathologic services can be performed only by or under the supervision of physicians, and

"Whereas, the Medical Society of the State of Connecticut has contracted for the physicians of the State of Connecticut with the Department of Defense to supply medical services to dependents of the Uniformed Forces under Public Law 569 of the 84th Congress (otherwise known as the Dependents' Medical Care Act) and

"Whereas, certification of medical services rendered can only be made by physicians.

"Be it therefore resolved that the Medical Society of the State of Connecticut hereby declares that Pathology is a medical service under the terms of the contract which has been negotiated between the Medical Society and the Department of Defense and as set forth in Contract issued by the Department of Defense in compliance with the Dependents' Medical Care Act, and fees for such services wherever rendered, must be paid to the physicians rendering the services."

The secretary pointed out that a similar resolution (No. 12) from the Medical Association of Georgia had been introduced before the House of Delegates of the American Medical Association at the New York meeting earlier this month and the House had voted to suggest that the AMA attempt to have "existing Medicare regulations amended to incorporate the Association's policy that the practice of anesthesiology, pathology, radiology and physical medicine constitute the practice of medicine, and that fees for services by physicians in these specialties should be paid to the physician rendering the service."

It was voted that this information be transmitted to Dr. Christie McLeod who had submitted the resolution on behalf of the Connecticut Society of Pathologists and that the resolution from the Connecticut Society of Pathologists be referred to the Committee on Hospitals of this Society for review and recommendation to the Council.

It was voted to authorize the Committee on Public Health to establish a Sub-Committee on Nutrition and to ask the Committee on Public Health to make nominations to the Council for members to serve on this Sub-Committee, to include the Society's representatives on the Connecticut Nutrition Council.

The Council is to prepare a statement of functions and purposes of the Sub-Committee on Nutrition.

A report of the Committee on Third Party Payments submitting a fee schedule for services rendered for the Railroad Retirement Board was presented and approved.

A letter from Dr. John P. Bachman, medical director of the State Department of Welfare was presented asking that the Society appoint a representative to the Special Group of Agencies and Organizations planning for the administration of Public Act 203, 1957, relating to the Adoption of Children. Dr. T. Stewart Hamilton, Hartford, was named to this assignment.

The secretary reported as follows on correspondence with Connecticut representatives of the United States concerning HR9 and 10, the "Jenkins-Keogh bills." Replies received from Connecticut representatives in the Congress showed that Mr. Cretella, Mr. May, Mr. Patterson, Mr. Sadlak, Mr. Seely-Brown and Senator Bush were in favor of this resolution and Senator Purtell made no commitment.

Reference was again made to "Standards and Recommendations for Hospital Care of Maternity Patients" and the following report on the subject from the Committee on Hospitals was presented:

"At the Joint Meeting of the Council on Professional Practice of the Connecticut Hospital Association and the Committee on Hospitals of the Connecticut Medical Society held in New Haven, May 15, 1957, the sub-committee, appointed at a prior meeting, reported on 'Standards and Recommendations for Hospital Care of Maternity Patients.' Dr. C. T. Schechtman, Chairman of the sub-committee, submitted his report, a copy of which I am enclosing. The two other members of the sub-committee, Drs. Alfred B. Sundquist and Ernest C. Shortliffe, read letters which had been sent to Dr. Schechtman. These letters will be of interest because they emphasize and bring out most of the points discussed by the group at this meeting.

On a motion made and seconded, it was

"Voted to accept the sub-committee's report and refer it to the parent organization (Connecticut Hospital Association or Council of the Connecticut State Medical Society) with the further suggestion that the 'Guide' be rewritten to be less specific in its attention to medical staff organization.

"As will be seen the sub-committee reacted unfavorably particularly to the precise definition of terms on the medical staff organization appearing on pages 2 and 3 of the 'Guide,' in which the individual hospital or staff has little choice in the matter of organization or policies. One specific objection was that the Chief or Chairman of the Obstetric Department should be 'responsible only to the Administration and Board of Directors or Trustees of the hospital,' thereby by-passing the medical staff. There were marked objections to the qualifications set down for the Chief or Chairman of the Obstetric Department as well as for the consulting staff." Signed by George H. Gildersleeve, M.D., chairman of the Committee on Hospitals.

The entire subject was discussed at length by many members of the Council and action upon the matter was postponed in the hope that Dr. Carl E. Johnson, chairman of the Society's Committee to Study Maternal Morbidity and Mortality would join the meeting. However, Dr. Johnson did not come, it later being learned that he was detained by an unavoidable personal reason and it was finally voted that the secretary should return the "Standards and Recommendations for Hospital Care of Maternity Patients" to the Committee to Study Maternal Morbidity and Mortality accompanying it with a copy of the report from the Society's Committee on Hospitals and ask that the Committee consider reviewing the "recommendations," to meet the objections raised by the Committee on Hospitals, and also to ask the Committee to provide the Council with the statistical data upon which the observations of the Committee were based.

It was voted to accept the invitation of the Fairfield County Medical Association to hold the 1958 Annual Meeting of the Society in Fairfield County, the exact place to be determined later.

Dr. Israel S. Otis reported for the Council's Subcommittee on Planning for the Thomas P. Murdock Scholarship and Loan Fund.

"The Sub-Committee consisting of Drs. Baker, Danaher, Fincke, Gibson and Otis as the result of their discussions have the following immediate recommendations to make to the Council for consideration at this time.

"1. That the minimum set for the Fund be fifty thousand dollars (\$50,000).

"2. That the Committee appoint and authorize an Executive Committee of five physicians from the Council to make plans for the selection and implementation in the name of the Council for a Committee of not less than fifty, and that this Committee be empowered to develop and promote a campaign towards attaining the desired goal.

"3. That the Formal Committee of at least fifty physicians and laymen be appointed and organized as an overall Committee to assist in raising of the Fund. This Committee appointed by the Council should comprise a membership of Statewide representation and significance.

"4. That the Council appropriate the sum of \$500 at this time for advance necessary expense towards the conduct of a campaign.

"5. Authorize the editor-in-chief of the *Connecticut State Medical Journal*

CUT STATE MEDICAL JOURNAL to have published an additional 300 copies of the July issue of the CONNECTICUT STATE MEDICAL JOURNAL for use at the time of the campaign."

It was voted to adopt this report and that the Executive Committee noted in paragraph 2 of the report be appointed as follows: Chairman, Dr. Otis, Drs. Barker, Danaher, Fincke and Gibson.

It was voted to renominate to Governor Ribicoff, Dr. H. Bruno Arnold, New Haven, to succeed himself as a member of the State Board of Examiners for Physical Therapists in accordance with Section 2203d of the General Statutes.

A proposal that the Society appoint a Joint Medical Society-Insurance Industry Liaison group with the Health Insurance Council which had been received from Mr. Louis A. Orsini, New York, vice chairman of the Council, was presented and discussed. Action upon the proposal was postponed until a later meeting of this Council when Dr. Thomas J. Danaher could be present to take part in the discussion.

The resignation of Milton F. Little, Hartford, from the Committee on Eye Care was accepted with regret and appreciation of the services that Dr. Little has given to the Committee and Dr. Dewey Katz, Hartford, was appointed to the Committee in place of Dr. Little.

The vacancy on the Conference Committee with the State Bar Association because of the death of Dr. Andrew J. Jackson was noted and a letter on the subject from Thomas M. Feeney, chairman of the Committee was presented. Dr. Feeney suggested that the number of members of this Society serving on the Conference Committee be increased to include representatives from the specialties of neurosurgery, orthopedic surgery, psychiatry and pathology. It was voted that the chairman of the Council should make additional appointments to the Conference Committee with the State Bar Association. Subsequent to the meeting the chairman of the Council with advice from several sources appointed

Peter V. Dingman, Daniel F. Levy, Averill A. Liebow, John F. Paget and Harold S. Wright to be additional members of the Committee and these physicians have agreed to serve.

Virginia Jane Anderson, New Canaan, Boston University Medical School, 1960, was elected a student member of the Society.

It was voted that the Society endorse the Development of the College of Nursing of the University of Bridgeport.

Dr. Ogden reported on a recent community meeting in Middletown at which there was discussion of the need for broader coverage of anesthesia under the Connecticut Blue Cross contract.

It was voted to direct the secretary to inform Connecticut representatives in the Congress of the United States the results of the Society's recent referendum on social security coverage for physicians and to notify the secretary and general manager of the American Medical Association of this action.

Dr. Gallivan reported briefly concerning the present discussions between ophthalmologists and opticians relating to the dispensing and fitting of eyeglasses by physician-ophthalmologists.

It was voted that no Council meetings be held in July and August unless called by the chairman for special urgent reason and that the date for the next regular meeting of the Council in September be set by the chairman of the Council and the secretary. The date for this meeting is tentatively set for Wednesday, September 18.

The meeting adjourned at 6:00 P. M.

Meetings Held in July

July 9—Connecticut Medical Examining Board

July 10—Connecticut Medical Examining Board

Committee on Maternal Morbidity and Mortality

July 11—Connecticut Medical Examining Board

July 30—Connecticut Medical Examining Board

INSURANCE AND THE PHYSICIAN

THE REAL PROBLEM IN HOSPITALIZATION INSURANCE

E. A. VAN STEENWYK, *Philadelphia, Pennsylvania*

The Author. *Executive Vice President, Associated Hospital Service of Philadelphia*

THE miracles of modern medical science have borne curious fruit. By successfully extending the span of human life they have brought us face to face with new dilemmas. For when Robert Browning described age as "the last of life, for which the first was made," he neglected to add that while these years can be our happiest, too often they include times when we are long on needs for medical attention, and short on funds.

The eyes of hospital administrators and economists, physicians and philosophers, publishers and politicians, now focus ever more steadily—and uneasily—on the older age group.

Recent significant surveys, some accompanied by near desperate calls for action, bring such facts home to the hospital world with sharp impact. They have inspired many hospital administrators to take a closer look at their own situations. Have you worried about the trend of costs, about the need for expansion? Have you wondered about how you were going to meet the growing demand for service among those least able to pay? Brother, you're not alone.

Last fall an administrator we know, head of a 250 bed hospital, needed faster bed turnover or the expanded plant he had just finished would already be inadequate. He ordered a study of all patients then in the house. The results? While learning that 75 per cent of the patients belonged to Blue Cross, he further discovered that 39 of the Blue Cross subscribers then in his hospital had an average age of 73! More significantly, from his social service worker he learned that 27 of these would have no resources to pay for care when their Blue Cross benefits ran out.

As a result, this administrator now has a better appreciation of the unique service Blue Cross performs in his community, not only in financing the care of so many of the patients in his hospital, but especially in providing coverage for the aged, most of whom require longer stays and would be "free" or "part pay" patients without Blue Cross.

His study has shown him, as it will any administrator, how uniformly Blue Cross continues coverage for its subscribers when they retire into those years when they would represent a serious hospital problem. Older patients not only need more frequent and extensive care but have little money of their own to pay hospital bills. Providing them with protection as well as those who leave their jobs with their health impaired, our friend has been reminded, is an important difference between Blue Cross and most commercial insurers. Recent studies highlight this same view.

One of the most interesting of these is the survey of Harland Fox.¹ Before presenting, in regard to the aged, a detailed critical analysis of ordinary group insurance policies and Blue Cross, he points out such salient facts as these:

In 1953, 8 percent of our total population were 65 or older. By 1957 it is expected to be 10 per cent, or 21,000,000 persons.

Also in 1953, 20 per cent of all patients in our hospitals were 65 or older. Make your own estimates as to what that percentage will be in the coming years!

And here's the pay-off: In 1954, three out of five U. S. families with income under \$2,000 were headed by people 65 or older.

While it is inescapable that economic problems of hospitals created by the aged will become more acute, it is just as apparent from Fox's study that the Blue Cross community-wide service principle approach offers the only acceptable solution.

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For only nonprofit plans such as Blue Cross have made a consistent effort to provide practical protection for the aging. Unlike ordinary insurers, Blue Cross never cancels a subscriber's coverage because of his age, retirement or after leaving employment because of frequent or prolonged illnesses. Under Blue Cross, group coverage may be converted to a "direct payment" basis at fair rates and benefits. When you tie this advantage to the "service principle" you see at once why the American Hospital Association and Blue Cross Plans have established standards of coverage and operation to which each Plan must adhere in order to obtain the coveted stamp of approval.

The "serious gaps" in commercial hospital insurance have been called even more forcibly to public attention by the recent report of the Legislative Committee on Health Insurance in New York State. State Senator George R. Metcalf of Auburn led this effort, working with the staff from two Columbia University graduate schools.

Among important recommendations² presented to Governor Harriman was one calling for all health insurance policies to continue through the life of the individual, not subject to cancellation because of age, leaving employment, or physical disability. In other words, make all policies like Blue Cross.

A third study by Roemer and Myers³ details the experience of the Saskatchewan Hospital Service Plan. Briefly, 27,746 male patients in the study group had 37,858 admissions in 1954. In that year there were therefore 10,112 second, third or higher repeat admissions. During the five years, 1950-54, the same 27,746 patients experienced 72,196 hospital admissions. But note this: Of the 27,746 patients, 11,009 received hospital care only once during the five-year period. The remaining 16,737 patients were admitted to the hospital 61,187 times, an average of four admissions each. The 11,009 individuals with only one admission used 12.2 days per individual during the five-year period. The 16,737 individual patients with two or more admissions used an average of 54.2 days per individual.

This is the reason why most insurance policies are discontinued once the policy-holder becomes seriously ill. The insurance company pays the first hospital or medical bill. This is in the contract, but the policy-holder is soon notified that his policy is cancelled or the rate drastically increased. How many more studies will be needed before the problem of the distribution of medical care expense is more generally understood? Have our day-to-day

problems made us lose sight of the basic reason for nonprofit hospital insurance?

We are going to hear much more on this subject, and from many quarters, in the near future. With the discussion should come a deeper realization of that solid concept on which Blue Cross has stood from the beginning—striving to serve all the people and all the hospitals. By their honest comparisons these independent studies are making ever more clear the distinctive nature of Blue Cross as a vital social force in a free economy.

A word to administrators and trustees: Why not survey the patients in your hospital? Find out how many of those—old and young—who have difficulty in meeting their hospital bills might have been eligible for Blue Cross. Equally important, find out how many with Blue Cross coverage could not have obtained other adequate coverage or been without funds to meet their hospital bills. Determine how much of your trouble can be laid at the door of inadequate insurance. The results, while surprising, can prove extraordinarily effective, particularly if put to good use by those trustees and administrators who command the attention of legislators, or high industrial management and union leaders interested in the welfare of your hospital.

The *New York Times* not long ago concluded an editorial on Health Insurance Gaps⁴ with this thought-provoking warning: "It is clear, from the public point of view, that the wider the coverage of voluntary health insurance the better, within the limits of manageable premiums—especially if we are to avoid compulsory government insurance in the United States."

For those administrators and trustees who have given but partial support to their community's Blue Cross it is later than they think. The ever growing national sympathy for the plight of the aged—those who have left their employment and are therefore no longer insured and those whose health is impaired—is a powerful force that will not—and should not—be abated.

REFERENCES

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Special Article

COMMUNITY OBSTETRICAL STUDY

A Project to Develop and Demonstrate Methods for an Evaluation of Obstetrical and Newborn Services of Hospitals in Hartford County, Connecticut

SUITABLE statistical information about the care of maternity patients and newborn infants in hospitals can be a major tool in the hands of physicians (a) to improve the quality of patient care through self evaluation of services, (b) to improve quality and effectiveness of teaching, and (c) to identify leads for further research. Experience in a number of hospitals has demonstrated clearly that statistical study of patient records improves the records themselves, and brings about a reduction of perinatal mortality.

In 1950, a voluntary organization known as the Obstetrical Cooperative was formed. Three hospitals in Baltimore constituted the nucleus of the Cooperative. These hospitals delivered 8,000 patients in 1950. It was agreed that common terminology and definitions would be employed. For the year starting July 1, 1956, the following hospitals participating in the Cooperative will deliver approximately 30,000 patients: University of Maryland, Sinai Hospital of Baltimore, Kings County Hospital, Long Island College Hospital, University of Colorado, Mount Sinai—New York, Beth-El Hospital—New York, Maimonides Hospital—New York, Yale University, Long Island Jewish Hospital, University of Miami, Baltimore City Hospital.

This cooperative venture has more than lived up to the aims set forth in the first paragraph above. It is therefore thought that the experience gained over the past seven years may be applied to collecting similar data from an entire community.

The Obstetrical Statistical Cooperative as a whole, and each member institution individually, have been impressed by the valuable self evaluation made available through the operation of the project. The ability of individual obstetricians to readily examine themselves, and to evaluate their results, has been an outstanding advantage. It is felt that if institutions of the type constituting the Cooperative (teaching hospitals) find such evaluation to be of importance, it must certainly follow that the benefits which will

accrue to the professional staff of the hospitals in an entire community will be even more striking.

In order to consider broadly the desirability and probable success of the extension of such a research project, the Children's Bureau called an advisory conference in Washington, D. C. on December 3, 1955. The participants in this conference were drawn from members or staff of the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Hospital Association, Joint Commission Accreditation of Hospitals, National Office of Vital Statistics, National Institutes of Health, American Public Health Association, North Carolina Fetal and Neonatal Mortality Study, and several experts in the field of biostatistics. It was the consensus of those participating in the conference, that this research project should be encouraged and supported.

It was believed that such a study would substitute clinical judgment based on statistical results for "clinical impressions."

Here is an example in the Obstetrical Cooperative of how this result has occurred: At one medical center an attempt is being made to evaluate the perinatal mortality rate by using statistical data according to the method described in the proposed project. In spite of the fact that the level of perinatal mortality was not excessive at gross evaluation, a more detailed analysis in the statistical study showed that significantly higher perinatal mortality was associated with breech deliveries of multigravid patients. At this particular hospital, there had been inadequate concern over this particular group of patients, since, in most instances, they previously had delivered full term infants by vertex presentation. As a result of this statistical study, the medical staff at this hospital has come to handle all breech deliveries with more concern and subsequently there has been a marked decrease in perinatal mortality associated with breech delivery.

Following the December 3, 1955 meeting, mem-

bers or representatives of the American College of Obstetricians and Gynecologists and of the American Academy of Pediatrics presented the project to their respective groups. The proposal then outlined received the approval of the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the Children's Bureau.

The Connecticut State Department of Health now proposes to conduct such a project locally in the hospitals of the City and County of Hartford.

The chief purpose of the study is to improve the quality of patient care on obstetrical and newborn services. Headquarters of the project will be at Hartford Hospital. The study will cover a two year period.

A joint committee, which consists of the representatives of the intra-hospital advisory committees and representatives of the local department of health and the state department of health has been formed. This committee will participate in the planning and implementation of this study, will assist in the setting up of conferences on maternal and newborn care in local hospitals and at meetings of the local medical society.

Reports of progress of this study will be made to this committee by the project staff semi-annually and annually.

This One Will Kill You The Human Factor

The human factor is killing your patients. Over three thousand people died in 1953 from blood transfusions of the wrong blood. More deaths from blood transfusions than from appendicitis, more than from all anesthesia. The wrong blood—the right patient; the right blood—the wrong patient. Why was the wrong bottle used?

Studies show that less than 10 per cent of the mistakes were due to technical inaccuracies in the laboratory. Over 90 per cent were due to the human element—the Hu Factor. The blood type and group were matched carefully, then someone used the wrong pint. The technologist issued the wrong bottle, or the nurse went to the wrong room, the intern didn't check the name tag, the attending physician didn't make sure of the label. Read the label before you stick the vein.

Yes, our science is ahead of us. And this in the face of more blood being used. Unnecessary transfusions may spell death. One medical audit study

of the abuse of transfusion shows one-third to be in error—given without sufficient indication or not given when indicated. Blood is now being given at the rate of ten pints per hospital bed per year—and this is going up. This isn't necessarily a bad sign, but it means we must be alert to dangers. Blood banks that keep a careful check show a 5 per cent reaction rate—major and minor reactions.

BEWARE AND BE AWARE

1. Give blood for serious need only. Ask yourself—is this pint necessary?
2. Don't order blood as a "little spring tonic"—for minor indications. It is not only potentially dangerous but is an "Expensive Meal."
3. Support strict blood bank regulations and these will support the life of your patient.
4. Personally check the label of the blood for your patient.
5. Give blood before and after surgery—not during surgery (except for real emergency).

Remember—the life that the wrong blood takes may be your own!

AMA Organizes Committee on Industrial Nursing

A new committee on industrial nursing has been established by the American Medical Association's Council on Industrial Health. The committee was created to provide a "medical-nursing forum" for the consideration of problems of mutual concern. The industrial nurse is an extremely important member of the industrial health team. Occasionally problems and issues develop that need analysis by both doctors and nurses; the committee will help make this possible.

Members of the committee are Dr. Jermyn F. McCahan, Liberty Mutual Insurance Company, Boston; Dr. David H. Goldstein, New York University Postgraduate Medical School, New York; Dr. Emmett B. Lamb, Indianapolis; Katharine A. Lembright, R.N., American Nurses Association, New York; Dr. O. Tod Mallory, Jr., Employers Mutual Liability Insurance Co., Wausau, Wisconsin; Dr. Charles F. Shook, Owens-Illinois, Toledo, Ohio, and Sara P. Wagner, R.N., American Association of Industrial Nurses, New York. Clark D. Bridges, Chicago, of the AMA council, is secretary of the committee.

The committee will meet in September in New York City.

AMA NEW YORK JUNE 3 - 7, 1957

AMA Board of Trustees Gets Infusion of Young Blood — Attendance Breaks All Records — House of Delegates Votes Down Social Security for Physicians — Revision of Principles of Medical Ethics Approved — Medicare Program Considered — Guides for Relation with United Mine Workers Association Approved — New Statements on Medical Schools and Occupational Health Programs Proposed — World Medical Association Supported — Distinguished Service Award to Dr. Tom Spies — Special Citation to Mr. Henry Viscardi, Jr.

CONNECTICUT ON SCIENTIFIC PROGRAM

Charles M. Barbour and David M. Little, Hartford, Section on Anesthesiology.

Monroe Coleman, Stamford, and Spencer F. Brown, Darien, Session on Allergy.

Sung J. Liao, Rocky Hill, Section on Physical Medicine.

CONNECTICUT IN EXHIBITS

Howard M. Spiro, New Haven, Conference on Diet.

Stuart C. Finch and Katherine D. Detre, New Haven, Exhibit on Experimental Medicine.

Edward H. Hon and Orvan W. Hess, New Haven, Exhibit Symposium on Perinatal Problems.

CONNECTICUT IN HOUSE OF DELEGATES

Thomas J. Danaher, Torrington, Member Council on Medical Service, Delegate.

John N. Gallivan, East Hartford, Member Council on Industrial Health, Delegate, Chairman Reference Committee on Hygiene, Public Health and Industrial Health.

Stanley B. Weld, Hartford, Delegate, Director of and Chairman of Advertising Committee of State Medical Journal Advertising Bureau.

Stanley H. Osborn, Hartford, Member Council on Constitution and By-Laws.

Oliver L. Stringfield, Stamford, Alternate Delegate.

Benjamin V. White, Hartford, Alternate Delegate.

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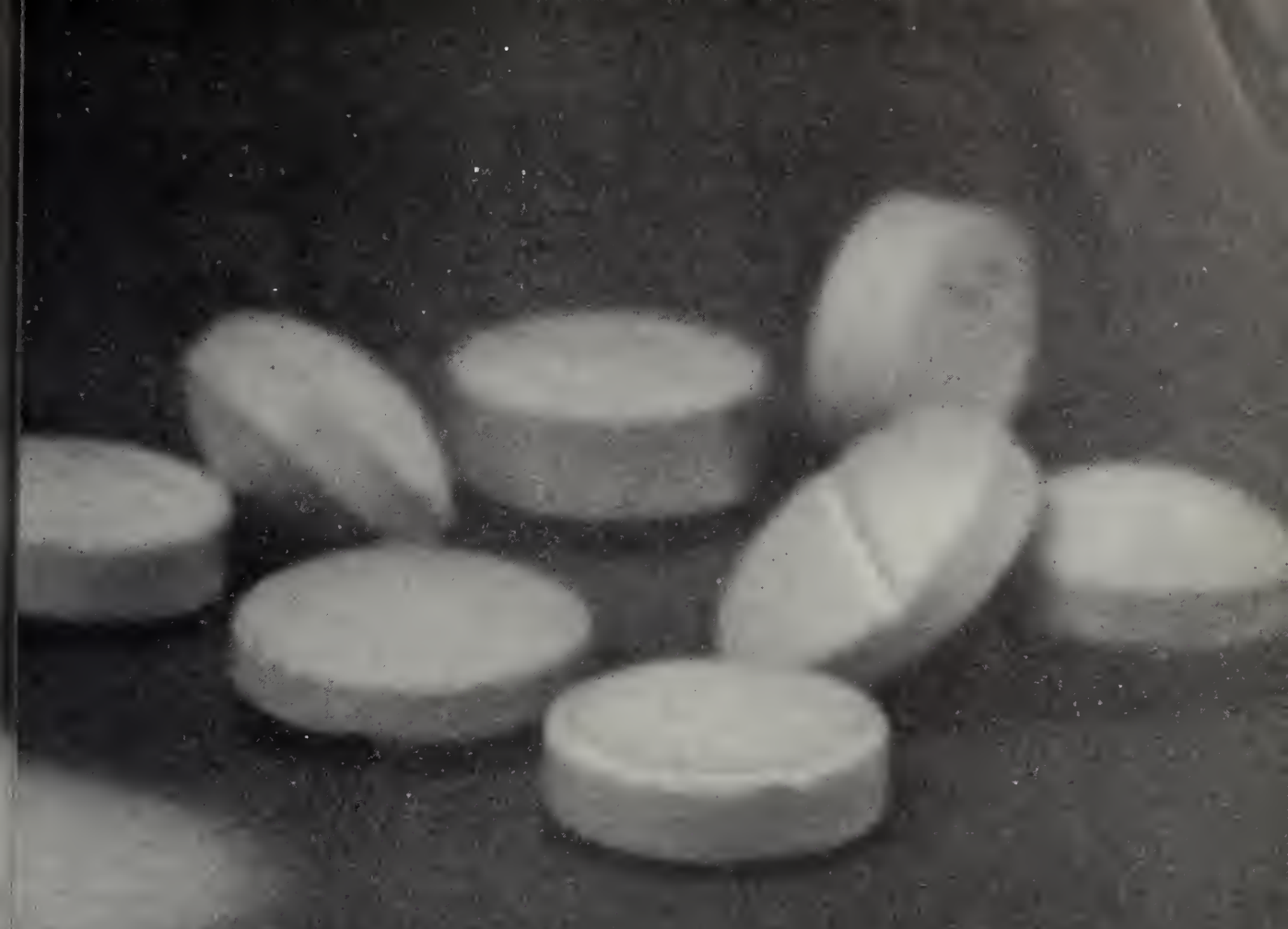
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(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: *Antibiot. Med. & Clin. Ther.* 3:378 (Nov.) 1956.

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ATTENDANCE

The American Medical Association's 106th annual meeting in New York was the biggest and probably the best ever held. Attendance set a new all-time record. Total registration for the five-day session was 55,847, including 19,469 physicians. At the AMA centennial meeting in Atlantic City in '47 the total number of physicians was 15,667. New York registration figures exceeded by far the totals for last year's Chicago meeting. Total registration then was 23,185, including 9,969 physicians.

ELECTIONS

Dr. Gunnar Gundersen of La Crosse, Wisconsin, member of the AMA Board of Trustees since 1948 and chairman for the past two years, was unanimously chosen president-elect for the year ahead. Dr. Gundersen, who also was first chairman of the Joint Commission on Accreditation of Hospitals from 1951 to 1953, will become president of the American Medical Association at the June, 1958 meeting in San Francisco. There he will succeed Dr. David B. Allman of Atlantic City, N. J., who became the 111th president at the Tuesday night inaugural ceremony in the Grand Ballroom of the Waldorf-Astoria Hotel.

In addition to Dr. Gundersen, the new president-

elect, the following officers were selected by the House on Thursday:

Dr. Jesse Hamer of Phoenix, Arizona, vice president; Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. E. Vincent Askey of Los Angeles, speaker, and Dr. Louis Orr of Orlando, Florida, vice speaker.

Four new members were elected to the Board of Trustees: Dr. George Fister of Ogden, Utah, to succeed Dr. James R. Reuling; Dr. Cleon Nafe of Indianapolis, Indiana, to succeed Dr. James R. McVay; Dr. James Z. Appel of Lancaster, Pennsylvania, to replace the late Dr. Thomas P. Murdock, and Dr. Raymond McKeown of Coos Bay, Oregon, to replace Dr. Gundersen. Dr. Edwin S. Hamilton of Kankakee, Illinois, was elected chairman of the Board at its organizational meeting after the elections in the House.

Dr. Homer L. Pearson, Jr. of Coral Gables, Florida, was renamed to the Judicial Council. Two new members were elected to the Council on Medical Education and Hospitals: Dr. Clark Wescoe of Lawrence, Kansas, to succeed Dr. Weiskotten, and Dr. Warde B. Allan of Baltimore, Maryland, to succeed Dr. F. D. Murphy of Lawrence, Kansas.

For the Council on Medical Service, Dr. Robert L. Novy of Detroit, Michigan, was reelected, and Dr. Hoyt Woolley of Idaho Falls, Idaho, was chosen to replace Dr. McKeown. Dr. Warren W. Furey of Chicago was reelected to the Council on Constitution and By-laws.

The most significant event may prove to be injection of much new blood in board of trustees, to wit, Drs. George M. Fister, Utah; Cleon A. Nafe, Indiana; James Z. Appel, Pennsylvania, and Raymond M. McKeown, Oregon. It has been years since as many as four vacancies were filled at one time. A troubled impatience with some of AMA's rigid policies was just perceptible in House of Delegates in session, though nothing approaching signs of revolt.

SPECIAL AWARDS

The House of Delegates voted the 1957 Distinguished Service Award of the American Medical Association to Dr. Tom Douglas Spies, head of the department of nutrition and metabolism at Northwestern University Medical School, Chicago, and director of the nutrition clinic at Hillman Hospital, Birmingham, Alabama, for his outstanding contributions to the science of human nutrition. For only

the third time in AMA history, the House also voted a special citation to a layman for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipient of this award was Henry Viscardi, Jr. of West Hempstead, N. Y., founder and president of Abilities, Inc., which employs only severely disabled persons.

The Goldberger Award in nutrition research was presented to Dr. Paul Gyorgy of Philadelphia. An AMA citation was awarded to Parke, Davis & Company for its continuing series of institutional advertisements telling the story of medicine and medical progress. Dr. H. G. Weiskotten, who retired after serving many years as chairman of the Council on Medical Education and Hospitals, received two bound volumes of letters of appreciation and also an ovation from the House of Delegates.

ACTIONS OF HOUSE OF DELEGATES

Revision of the Principles of Medical Ethics, relations with the United Mine Workers of America Welfare and Retirement Fund, the federal government's Medicare program, new standards for medical schools, a new statement on occupational health programs and the issue of Social Security benefits for physicians were among the wide variety of subjects acted upon by the House of Delegates.

SOCIAL SECURITY FOR PHYSICIANS

State delegations of New York and Connecticut introduced resolutions reversing the previous stand of organized medicine to coverage under the Social Security system. In addition, at the request of two members of the Connecticut State Medical Society one of its delegates introduced a resolution calling on the AMA to conduct a nationwide referendum of its members on this same question. All three resolutions were defeated. Both sides had eloquent spokesmen at reference committee hearings. One of them said, apropos of proposed referendum: "It's a dangerous precedent for this House to abdicate responsibility and take an issue direct to the doctors." The House vote confirmed this view and also recommended a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue. The House at the same time reaffirmed its support of the Jenkins-Keogh bills.

NEW PRINCIPLES OF MEDICAL ETHICS

The House approved the long discussed revision

of the Principles of Medical Ethics, originally submitted at the 1956 annual meeting in Chicago. The final version, presented by the Council on Constitution and By-laws and then amended by reference committee and House discussions in New York, now reads as follows:

"Preamble

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"Section 3. A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7. In the practice of medicine a physician should limit the source of his professional in-

come to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

"Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well being of the individual and the community."

In approving the new Principles of Medical Ethics, the House of Delegates also reaffirmed the "Guides for Conduct for Physicians in Relationships with Institutions," adopted in 1951, and requested the Board of Trustees to devise and initiate a campaign to educate both physicians and the general public to the dangers inherent in the illegal corporate practice of medicine in its various forms.

GUIDES FOR RELATIONS WITH UMWFA FUND

In a key action on the basic issue of third party intervention, as it affects the patient's free choice of physician and the physician's method of remuneration, the House adopted the "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund," which were submitted by the AMA Committee on Medical Care for Industrial Workers. In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third party groups such as management and labor union plans.

The statement, which outlines both medical society and UMWFA responsibilities, contains these

"General Guides":

"1. All persons, including the beneficiaries of a third party medical program such as the UMWFA Fund, should have available to them good medical care and should be free to select their own physicians from among those willing and able to render such service.

"2. Free choice of physician and hospital by the patient should be preserved:

"a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.

"b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the quality of medical care, and avoid the exploitation of his services for financial profit.

"c. The medical profession does not concede to a third party such as the UMWFA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.

"3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.

"4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local hospital staffs and by local governing boards of hospitals."

THE MEDICARE PROGRAM

The House considered three resolutions dealing with the federal government's Medicare program for the dependents of servicemen. The delegates adopted one resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern or other house officer in similar status who is participating in a training program." Government sanction of such payments, the House declared, would give impetus to the improper corporate practice of medicine by hospitals or other nonmedical bodies. Such proposals, the House added, would violate traditional patterns of American medical practices, seriously aggravate

problems of hospital-physician relationships, encourage charges by hospitals for residents' services to patients not under the Medicare program, and create a variety of additional problems in such areas as medical licensure and health insurance.

In another action on Medicare, the House recommended that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. In this connection, however, the House restated the AMA contention that: the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

The House also suggested that the AMA attempt to have existing Medicare regulations amended to incorporate the Association's policy that the practice of anesthesiology, pathology, radiology and physical medicine constitute the practice of medicine, and that fees for services by physicians in these specialties should be paid to the physician rendering the services.

NEW STATEMENT ON MEDICAL SCHOOLS

To replace the "Essentials of an Acceptable Medical School," initially approved by the House of Delegates in 1910 and most recently revised in 1951, the House adopted a new statement entitled "Functions and Structure of a Modern Medical School." Presentation of the document followed a year of careful study by the Council on Medical Education and Hospitals in collaboration with the Association of American Medical Colleges.

The statement is intended to provide flexible guides which will "assist in attaining medical education of ever higher standards" and "serve as general but not specific criteria in the medical school accreditation program." The document encourages soundly conceived experimentation in medical education, and it discourages excessive concern with standardization.

"No rigid curriculum can be prescribed for accomplishing the objectives of medical education," it states. "On the contrary, it is the responsibility of the faculty of each school continually to reevaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well integrated educational program."

OCCUPATIONAL HEALTH PROGRAMS

The House also approved a new statement on the "Scope, Objectives and Functions of Occupational Health Programs," submitted through the Board of Trustees by the Council on Industrial Health. The Board report to the House said: "The statement describes and defines orthodox in-plant medical programs as understood in this country today and distinguishes clearly between such programs and the various plans for comprehensive medical care of the sick. It should help to resolve misunderstandings concerning the specialty of occupational medicine."

In adopting the statement, the House agreed with a reference committee report which declared that "the House has before it a statement which for the first time clearly defines the scope, objectives and functions of occupational health programs. It marks the needs and boundaries of occupational medicine. It states in a positive fashion the proper place of occupational health programs in the practice of medicine and it clearly charts the pathways of communication between physicians in occupational health programs and physicians in the private practice of medicine."

DOCTOR DRAFT LAW

The House of Delegates approved a resolution introduced by a delegate from the California Medical Association opposing the extension of the Doctor Draft Law enacted in 1950. It also supported another resolution introduced by the same delegate calling for a continuation of the current system of Advisory Committees in the event the Doctor Draft Law were continued.

USE OF STIMULANTS IN SPORTS

One of the actions which made headline news in the press was the action of the House of Delegates in directing the Board of Trustees to investigate the indiscriminate use of stimulants such as amphetamine, particularly in relation to athletic programs. If such abuses are proven to exist the Trustees are empowered to act.

WORLD MEDICAL ASSOCIATION

The House approved a resolution introduced by a delegate from the Illinois State Medical Society supporting the World Medical Association, calling upon every member of the AMA to join the U. S. Committee of the World Medical Association and urging the component state associations to support and give recognition to the state chairmen and subcommittees of the U. S. Committee.

MISCELLANEOUS ACTIONS

In considering 69 resolutions and many additional reports from the Board of Trustees, councils and committees, the House also:

Congratulated the Board and the Committee on Poliomyelitis for their prompt action in stimulating national interest in the polio immunization program.

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of narcotic addiction.

Urged a more careful screening of television and radio patent medicine advertisements.

Directed the Speaker to appoint a committee of five House members to study the Heller Report, a management survey of the Association's organizational mechanisms.

Commended the Law Department for its special report on professional liability and urged state and county medical societies to establish claims prevention programs and to show the new film, "The Doctor Defendant."

Opposed the establishment of any further veterans' facilities for the care of nonservice-connected illnesses of veterans.

Condemned the compulsory assessment of medical men and staff members by hospitals in fund raising campaigns.

Voted to continue to hold the interim session of the House of Delegates at the same time and place as the Scientific Clinical Session.

Accepted the recommendation of the Board of Trustees that the present amount of 25 cents a member as reimbursement to the state medical societies for collecting AMA dues be continued, the state societies being allowed to formulate their own plans such as developing bank interest on monies collected and held in escrow.

Referred to the Board of Trustees a resolution calling for the establishment of a national research fund.

Referred to the Board of Trustees a resolution calling for an investigation into the growing shortages in certain specialties.

Approved the free choice of physicians by federal employees.

Approved a resolution to the effect that no new Board of Ophthalmic Surgery within the American Board of Ophthalmology be established.

Requested the Board of Trustees to direct the

Council on Drugs to develop a uniform system for identification of solutions in hospitals.

Commended the television program, "Dr. Hudson's Secret Journal," its producers and its star, Mr. John Howard, for an outstanding contribution to the public interest and welfare, and

Recommended payment of transportation expenses of Section Secretaries for AMA meetings which they are required to attend.

SCIENTIFIC EXHIBITS

The scientific exhibits on the third and fourth floors of the Coliseum were as usual the scene of a maelstrom of activity. The 550 odd exhibits were of varying types and quality. Some were teaching demonstrations of well known medical facts. Others described findings of recent investigations of a fundamental nature. A few were analyses of clinical case material. There was an occasional thinly disguised promotion of a proprietary drug. A number of exhibits were promoting various organizations dealing with social problems related in one way or other to the practice of medicine. For the discriminating and studious observer with a willingness to devote sufficient time to a few exhibits there was a wealth of material to be taken in.

One of the technically excellent exhibits was that of Reese and Straatsma on precancerous and cancerous melanosis of the conjunctiva. With excellent color photographs they illustrated such lesions which have a tendency to come on in middle life, to be flat, diffuse, pigmented and fluorescent, and they pointed out the differentiation from nevi, which are usually circumscribed and raised, as well as from congenital melanosis with onset at birth. Also among the ophthalmologic exhibits was one by Braley and Hamilton, pointing out the frequency of a progressive central retinitis in the presence of chronic amebiasis.

Weeks and Travell in the pediatric section demonstrated a technic for giving painless hypodermic injections by using a volatile substance like ethyl chloride to reduce skin temperature to 10° C. In order to avoid a "startle reaction" this is accomplished by squirting the volatile substance on a cotton pledget and rubbing it on the skin, rather than by spraying the skin directly. Another pediatric exhibit was that of Davis, Roberts, and DeSanctis on the management of the type of megacolon secondary to a long redundant sigmoid. In some

such cases a resection of the upper rectum sigmoid, and part of the descending colon appears to be indicated.

In preventive medicine Cooper and Cralley had a clear presentation on the silica hazard in the diatomite industry. The fossil skeletons of which the diatomaceous earth is composed are almost pure silica, and the incidence of silicosis in this industry has proved high. The material is used principally for filters. Also in the preventive medicine section Rivers had an excellent demonstration of the geographic distribution of Coxsackie and Echo viruses. Van Zile Hyde had a similar geographic epidemiologic exposition of the recent trend of yellow fever to extend northward into the temperate zones.

In the section on abdominal surgery Cattell, Warren and Colcock had a beautiful exhibit demonstrating the management of strictures of the extrahepatic bile ducts, the clinical features of these strictures, and a variety of methods for their surgical repair. Brush and Block presented evidence that intravenous calcium tolerance tests and phosphorus reabsorption tests are helpful in the definitive diagnosis of hyperparathyroidism. Devine and Devine pointed out the value of tape recordings of peristaltic sounds as affording more representative evidence in various types of ileus than one may obtain by brief auscultation of the abdomen. There were two exhibits on arterial grafts for arteriosclerotic impairment of the circulation in the lower extremities. Humphries, deWolfe and LeFevre claimed seventy per cent success in their overall series and eighty per cent in their elective cases.

Goldenberg, Lattimer, Cahill and Cohen presented what they described as a dependable test for pheochromocytoma based on the estimation of the catecholamine fraction of the urine by measurement of its fluorescence. In two thousand selected cases they discovered seventy-three abnormal values and all were found to have pheochromocytoma. In unselected cases of hypertension the incidence of abnormal tests is somewhat under 0.5 per cent.

In the anesthesiology group Hale, Kolff, and Effler presented a method of inducing elective cardiac arrest during surgery on the open heart by introducing potassium citrate into the root of the clamped aorta. After surgical repair is complete the clamp on the aorta is released, blood from the oxygenator flushes out the potassium, and the heart beat reappears. Adelman, Jacobson, Lief, and Miller

reported on clinical studies of promethazine as a premedicant drug in surgery and obstetrics, as a sedative adjuvant in spinal anesthesia, and as a specific anti-emetic in nausea and vomiting induced by drugs or following operation.

Among the dermatologic exhibits was one by Boucek, Noble, Casten, Elden, Kao and Woessner on the effects of relaxin on connective tissue. This hormone, which helps to maintain the relaxed state of the uterus during pregnancy, was found to affect favorably the trophic ulcers, Raynaud's phenomena, and skin tightness in scleroderma. These changes are alleged to be the result of the effect of relaxin on collagen.

Great interest was shown in an exhibit in the bronchial epithelium caused by smoking. Then observers showed that in smokers there was more evidence of basal cell proliferation, columnarization, squamous transition, carcinoma-in-situ and carcinoma than in nonsmokers.

In the section on experimental medicine and therapeutics two new anticoagulants were introduced, anisindone by Lange, Perchuk and Mahl, and acenocoumarin by Manchester and Putnam. Both of these drugs were heralded as having advantages over the antithrombic agents now in general use.

There were many others, and as usual the scientific exhibits constituted an important part of the AMA program.

The new Coliseum with its modern facilities for transportation to and from the various floors was most impressive. Best of all was the fact that no longer must visitors to the exhibits suffer from the heat and congestion of the old Grand Central Palace. To get a laymen's reaction to both scientific and commercial exhibits one should read the account in the *New Yorker*, June 22, 1957.

Physicians Appointed to State Hospital Posts

John Atchley of Salisbury and Oliver L. Stringfield of Stamford have been appointed by Governor Ribicoff to the Fairfield State Hospital Board of Trustees. Katherine H. Martin of Waterbury has been named to the Board of the Connecticut State Hospital at Middletown, and Mario J. Albamouth of Norwich to the Norwich State Hospital Board.

FROM OUR EXCHANGES

Bleeding from the upper gastrointestinal tract is a problem of great complexity and needs individual management. It should never be subject to the hazards of generalization. Smythe *et al.* analyze 111 cases from the service of the Boston City Hospital (*New Eng. Jour. Med.*, 256:10, pp. 441-447). Massive gastrointestinal hemorrhage has a high mortality rate in spite of an aggressive approach to diagnosis and therapy. The management of younger patients (under sixty years of age) with uncomplicated peptic ulcers that bleed commonly present few problems. The management of elderly patients, on the other hand, who present themselves with bleeding ulcers is far from satisfactory.

Advanced age and liver disease the authors found to be the most serious complications associated with gastrointestinal hemorrhage. Bleeding from causes other than ulcer were associated with the highest mortality rate, as well as the most frequent occurrence of liver disease. This last group in addition comprised the most serious diagnostic problem.

The authors point out that we must accept the fact that in a given hospital, time and situation, the facilities, personnel and experience of all concerned may properly favor decisions for or against emergency surgery, "these being factors quite apart from the proximate medical characteristics of the patient." Such factors include limited supplies of blood, lack of resident physicians or inadequacy of nursing care, as well as availability of expert anesthetists and surgeons skilled in dealing with gastrointestinal hemorrhage.

* * * *

On the word of Taylor, chronic gastric ulcer constitutes only a small part of the overall peptic ulcer problem (*Jour. Ind. State Med. Assoc.*, 50:3, pp. 285-286).

Dr. Taylor considers that chronic gastric ulcers are associated with an appreciable number of unsuspected gastric carcinomas. It is for this reason that the treatment of chronic gastric ulcers cannot parallel that of other peptic ulcers.

If we are to make any inroads upon gastric cancer it will not be in that group in which the diagnosis is obvious. The author does not advocate immediate

gastric resection in all cases of gastric ulcer. However, it may be added that he does not approve of treating gastric ulcer "to death." He does think gastric resection is mandatory in those patients that have passed middle age and who have achlorhydria and gastric deformity. The operative treatment of benign gastric ulcer "is a very satisfactory procedure."

* * * *

In discussing "Some Aspects of the Surgeon's Work in the Tropics" Markowski calls attention to the paradox that the use of antibiotics, preventive medicine and elevated standards of hygiene have prolonged the lives of the people living in the tropics only to increase the number of patients coming to the surgeon with neoplasms (*Jour. Internat. Coll. Surg.*, XXVII:4, pp. 410-427).

The author believes that people in the tropics are more predisposed to benign or malignant growths than people living in temperate climates. This last note is only an opinion, not supported by any facts.

* * * *

"The Management of Sleep Disturbances; Experience with a New Hypnotic Preparation" is the title of an article by Browning appearing in *The Journal of the Medical Society of New Jersey* (54:1, pp. 4-6). A newly released preparation of Secobarbital was given to 28 victims of insomnia. The doses ranged from one and one half to two and one quarter grains, taken in a capsule form at bedtime. Most of the patients slept uninterruptedly for six to eight hours. Four patients slept less than six hours. Two patients complained of feeling groggy or slightly fatigued the following morning, the only side effects noted.

Secobarbital, according to the author, overcomes two shortcomings of currently available hypnotics. Short-acting hypnotics often fail to provide uninterrupted sleep. Long-acting drugs usually do not produce sleep immediately and often cause grogginess. Because Secobarbital induces sleep promptly and maintains a uniform level of sleep throughout the night it should prove useful in all cases of insomnia.

* * * *

Phillips *et al.* do not consider that Meprobamate addiction is a fanciful danger (*Northwest Med.*, 56:4, pp. 453-454). Meprobamate is one of the most useful of the sedating or tranquilizing drugs. However, it is a drug that should be treated with respect. Being considered a safe, harmless and innocuous medication it has been easy for both the patient and the doctor to relax their usual careful observation of the effects. The authors cite two cases in which they observed the toxic and withdrawal phase of the drug. Their conclusion is that Meprobamate is a very useful drug, but also that it is a medication that should be carefully supervised by the prescribing physician.

* * * *

Physicians too often forget that oxyuris vermicularis can be the cause of serious complications by migration into appendix, vagina, uterus or Fallopian tubes. Gregory found in 350 cases of appendicitis (acute) that 16, or 4.6 per cent, were caused by oxyuris vermicularis (*Jour. Maine Med. Assoc.*, 48:1, pp. 5-6). When a definite diagnosis of oxyuris vermicularis has been made the suggested treatment is gentian violet. The dosage is 10 mg. per year of apparent age in children, given every four hours for seven days and 60 mg. three times a day for adults. Between courses there should be one week without the drug.

* * * *

In recent years surgeons have become increasingly aware of the significant role of obstruction of the common bile duct at the sphincter of Oddi. This has been particularly true in patients with recurrent biliary symptoms after a cholecystectomy.

Cattell *et al.* review a series of 100 cases with stenosis of the sphincter of Oddi and stricture of papilla of Vater (*New Eng. Jour. Med.*, 256:10, pp. 429-435).

This condition may be responsible for repeated attacks of severe pain in the right upper quadrant of the abdomen, with or without associated jaundice. If unrecognized and not corrected at the initial operation, it may result in persistent symptoms which will require reoperation. The authors believe that partial obstruction of the common bile duct due to a stenosis of the sphincter Oddi may result in the development of common-duct stones. The condition is most effectively treated by transduodenal sphincterotomy, with or without the implantation of a long-arm T tube.

* * * *

"Are Physicians Educated" is a fair question; and one that most of us would happily answer—and without much thought—with the single word "Yes."

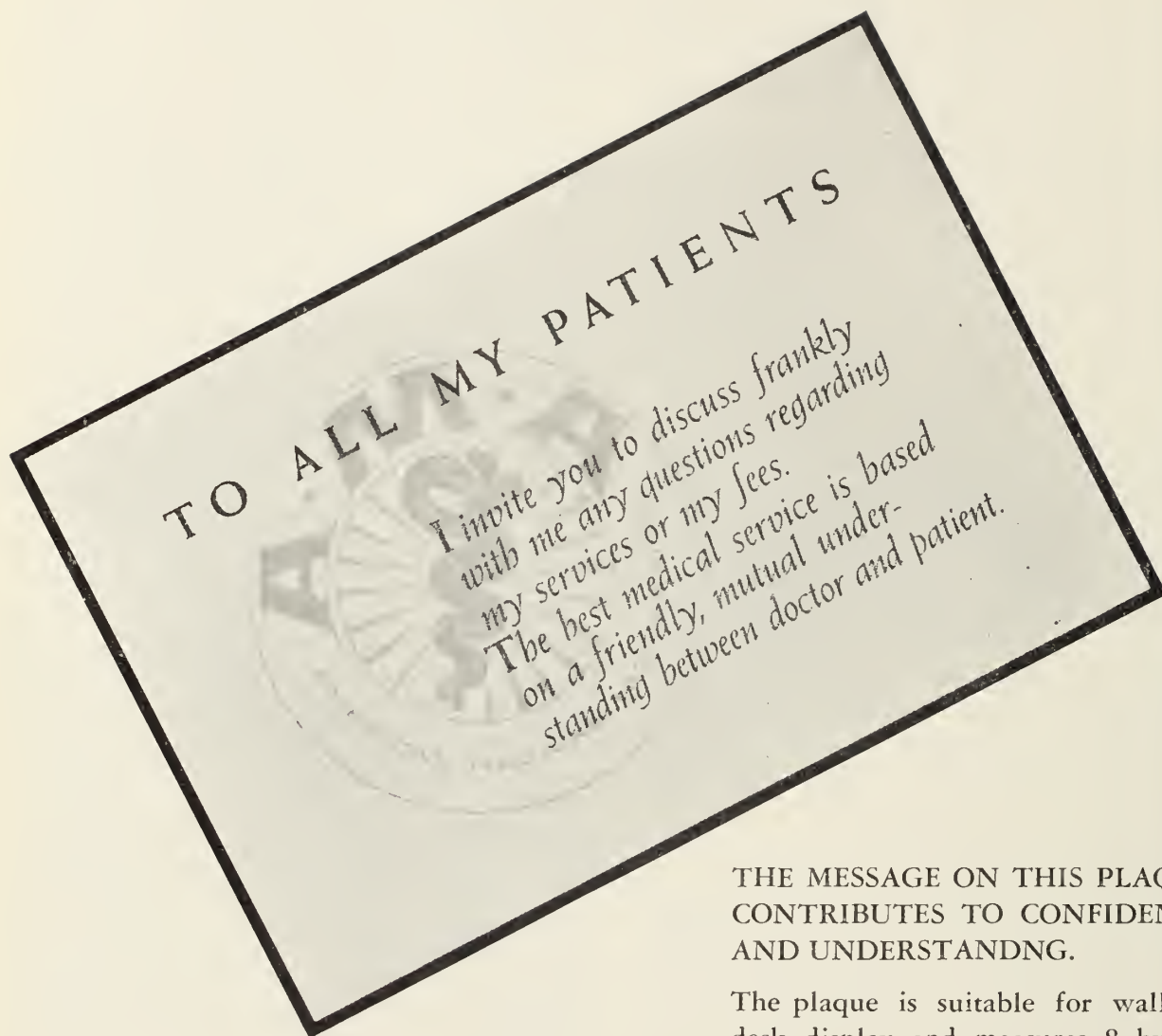
Frohman devotes considerable space elaborating his doubts on the matter (*Jour. Okla. State Med. Assoc.*, 50:3, pp. 100-114) and pointing out that the doctor may be competent without being wise. It is this everyday wisdom that should be looked for and which the general practitioner might very well bring into the medical schools, the clinic and the hospital. If added science tends to make the physician less and less the human being he is supposed to be, then we have reason to fear for our future generations of doctors. People want human physicians to get them well if possible. They are not healed by machines or by laboratory formulae, however brilliant. Today there is a vague dissatisfaction with the doctor as a person; people feel that he has become too commercial or too scientific, too busy or too preoccupied to concern himself with their problems.

The physician must be a lifelong student. The general practitioner is no exception to the rule. He comes out of medical school with at least a minimum of professional knowledge; but who can be sure of the state of his knowledge in five or ten years after graduation? The specialist can be trusted to take care of himself; the conditions of his existence demand that he keep abreast of the times. The general practitioner is in a somewhat different category. He should be carefully nurtured by the medical schools and by the local hospital and should be guarded by the public. Humanly speaking with the general practitioner are the responsibilities and the issues of life and death.

* * * *

Owben concludes his lecture on "Permanent Anticoagulation Therapy in Cardiovascular Disease" in these words: "In summarizing our results of permanent anticoagulant treatment, we think that the therapy affords protection against embolization in patients with rheumatic heart disease and against infarction and death in cases with angina pectoris or recent myocardial infarction. The therapeutic results also suggest a pathogenic relationship between blood coagulation, thrombus formation and clinical coronary disease." (*Northwest Med.*, 56:3, pp. 298-307.)

* * * *



THE MESSAGE ON THIS PLAQUE CONTRIBUTES TO CONFIDENCE AND UNDERSTANDING.

The plaque is suitable for wall or desk display and measures 8 by 12 inches. It is available to physicians at a nominal charge by using the coupon on this page.

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Enclosed is a check for \$1.25. Please send a copy of the AMA office plaque, "To All My Patients."

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PUBLIC RELATIONS

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Committee on Rural Medical Service Plans Fair Exhibits

The country fair project sponsored by the Society's Committee on Rural Medical Service, in cooperation with the Woman's Auxiliary to the Society and Connecticut Medical Service, will include exhibits at twelve fairs starting August 31.

The exhibits will present information concerning the network of 17 emergency call plans operated by local and county medical associations in major population centers. A message concerning the value of voluntary health insurance will be incorporated in the script.

The table-type exhibits are especially designed for portability and ease of handling. They will be managed by teams from the county chapters of the Auxiliary. Leaflets describing the medical plans and other medical services will be available to those visiting the exhibits. Arrangements for the project are now being completed and exhibit space has been requested at the following fairs: Goshen Fair, Goshen, August 31, September 1-2; Wethersfield Grange Fair, Wethersfield, September 5-6; North Haven Fair, North Haven, September 5-8; Bethlehem Fair, Bethlehem, September 7-8; Echo Grange Fair, Mansfield, September 7; Berlin Grange Fair, Berlin, September 13-14; Harmony Grange Fair, Monroe, September 13-14; Guilford Fair, Guilford, September 20-21; Union Agricultural Society Fair, Broad Brook, September 24-25; Stafford Fair, Stafford Springs, October 3-6; Glastonbury Grange Fair, Glastonbury, October 12; Riverton Fair, Riverton, October 12-13.

Emergency Medical Card Used in State Project

The Emergency Medical Card produced by the Society's Committee on Public Relations is being incorporated in a project sponsored by the Connecticut Chapter of the National Farm Bureau Federation.

The national project is based on an emergency card modeled after the Connecticut version and produced for the Federation by the American Medical Association's Council on Rural Health. Copies of the Society's emergency card have been requested and limited distribution is being made to local health committee chairmen of the Connecticut organization. The card is a wallet-size record of such medical information as might affect the course of treatment during an emergency away from home. This information, briefly recorded at the time of a physical examination, comprises the inside portion of the card when folded. The outside of the card contains identity information and can replace the usual type of card carried by most persons. The card is printed in green and black on white stock and a detachable third portion contains a brief message explaining the purpose of the card.

Sample copies of the card are being distributed by counties for physician information and comment. It is planned to utilize this information for such revision of the card as may be indicated to increase its usefulness.

AMA Sponsors Annual PR Institute

The 1957 Public Relations Institute of the American Medical Association will be held in Chicago, August 28-29.

Three main problems in writing and publishing articles containing medical information will be discussed the first day of the conference, as follows: (1) Problems of science writers in developing articles of national significance; (2) Press relationship problems in covering local medical news; (3) Ethical considerations in distinguishing between advertising and legitimate medical news.

A film portraying the services of the AMA, "Whitehall 1500," will be premiered and a slide-film depicting mechanical devices used in quackery will be shown as two new aids for use by local associations.

Representatives from state and local associations

will participate in a series of panel discussions scheduled for the afternoon program August 28. The second day of the conference is being planned to include a wide variety of discussion groups on topics relating to community services.

New Guide on Voluntary Health Agencies

A new "Guide to Relationships Between Medical Societies and Voluntary Health Agencies" has been prepared by the American Medical Association. Prepared by the Committee on Relationships Between Medicine and Allied Health Agencies, the booklet points up the nature of voluntary health agencies, the questions that need to be answered in evaluating such agencies, the medical society's obligations to voluntary agencies, and the voluntary agency's obligations to the medical society.

Last fall the committee issued a brief outline on this subject which stimulated such interest among medical societies that the more detailed and comprehensive set of guides was prepared.

Copies of the publication may be obtained from the Council on Medical Service, AMA.

Film Portrays Role of Radiologist on Medical Team

A new color motion picture dedicated to the practice of radiology has been added to the AMA's film library.

"First a Physician" tells the story of training in radiology, what this specialty comprises and how the radiologist serves patients. The film was produced by E. I. du Pont de Nemours & Co., Inc. in cooperation with the American College of Radiology.

Medical societies may arrange for bookings through the Film Library. The film is suitable for school, club and other public gatherings.

Drop in Mortality Rates

The following is quoted from Vol. VI, No. 4, *Progress in Health Services*, April, 1957:

CONTROL OF THE COMMUNICABLE DISEASES

The U. S. Mortality rate from tuberculosis, pneumonia and influenza has dropped more than 90 per cent since 1900.

In 1900 the three leading causes of death in this

country were all diseases of a communicable nature: pneumonia and influenza; tuberculosis; and diarrhea and enteritis. These three disease-groups, with a combined death rate exceeding 500 per 100,000 population, accounted for nearly a third of all deaths.

By 1956, with corresponding death rates per 100,000 of around 28, 9 and 5, respectively, the combined rate from these diseases had dropped to just over 40, or less than one-twentieth of all deaths. Mortality from most other communicable diseases had also been brought to exceedingly low levels and in some cases almost eliminated.

THE DOCTOR'S OFFICE

Ambrose Alfonsi, M.D. announces the opening of an office for the practice of general surgery at 1 North Main Street, Southington.

Louis W. Cappucci, M.D. announces the opening of an office for the practice of internal medicine at 291 Whitney Avenue, New Haven.

Daniel Kahn, M.D. announces the opening of an office for the practice of internal medicine and cardiology at 130 East Main Street, Meriden.

Erwin D. Niesyn, M.D. announces the opening of an office for the practice of internal medicine at 2220 Main Street, Stratford.

Ralph T. Ogden, M.D., Wendell C. Hall M. D., C. Leonard Smith, M.D., William A. Goodrich, M.D., John H. Woodruff, M.D., Douglass J. Roberts, Jr., M.D. announce the association of Arnold H. Janzen, M.D. in the private practice of radiology at 85 Jefferson Street, Hartford.

Philip Radding, M.D. announces the removal of his office to 600 Asylum Avenue, Hartford. Practice limited to orthopedic surgery.

Morris J. Seide, M.D. announces the opening of an office for the practice of internal medicine at Bishop's Corner, 2535 Albany Avenue, West Hartford.

Howard A. Schwartz, M.D. announces the opening of an office for the practice of pediatrics at Bishop's Corner, 2535 Albany Avenue, West Hartford.

Henry M. Williams, M.D. announces the opening of an office for the practice of internal medicine and medical neoplasia at 85 Jefferson Street, Hartford.

NEWS FROM WASHINGTON

Eisenhower Signs Revised Doctor Draft Bill

The revised doctor draft bill has become Public Law 85-62; it was signed by President Eisenhower June 27, four days before the expiration of the old doctor draft law. Under the latter, some 10,000 physicians were called up for two or more years of service, starting back at the time of the Korean war. The new law provides for the selective call-up of physicians and dentists to age 35 if they were deferred from the regular draft at any time after June, 1951, in order to complete their professional training. The law is effective for two years, expiring at the same time as the regular draft. Defense Department estimates that the 2,200 physicians required by the services this fiscal year will come from volunteers.

The Office for Dependents Medical Care

Has reported that as of mid-May, 36,922 billings have been received from civilian hospitals caring for "Medicare" patients. Payments have totaled more than \$3,560,000. The average cost per hospital claim has been slightly more than \$96.

Physicians' claims have totaled 53,802 at an average cost of about \$68 per claim. Total disbursements for physicians' claims have been in excess of \$3,600,000.

It is reported that Air Force personnel have accounted for 41.5 per cent of the claims paid for under the program. The Navy, Army and Public Health Service have accounted for 32.5 per cent, 23.7 per cent and 2.3 per cent of the cases, respectively. The dependents medical care office reports that maternity care represented 37.9 per cent of all the cases paid with tonsillectomies running second at 17.4 per cent.

Senate Votes More Funds for Medicare in Civilian Hospitals

The Senate has voted to restore \$1.5 million for the armed forces medicare program. The money, contained in the Defense Department appropriation bill, includes the fund for care of dependents in

civilian facilities. The Senate acted July 2 on recommendation of its Appropriation Committee. Both the committee and the Senate ignored the suggestion of the House Appropriations Committee that Defense regulations be changed to favor more extensive use of military facilities over civilian hospitals for dependents. The American Medical Association had claimed that the Navy had supplied the House with misleading information on comparative costs in military and civilian hospitals, which prompted the House Committee action.

VENDOR MEDICAL PAYMENTS

The Senate version on vendor medical payments for persons on public assistance rolls (HR7238) has prevailed in a conference with the House. As a result States may use the vendor method now in operation in some States or the method provided by the 1956 amendments to the social security act. The House wanted States to have a third alternative: a combination of both methods. The Senate figures its version will save \$17.8 million as against the House version.

DISABILITY FREEZE

The Senate has approved and sent to the White House HR6191 giving another year for disabled persons to apply for retroactive benefits under OASI.

VOCATIONAL REHABILITATION

The Senate passed and sent to the House S1971 which permits Office of Vocational Rehabilitation grants to residents in physical medicine and rehabilitation through the third year of training. Under present law, such grants cover only two years.

AMA Challenges Claim of High Civilian Medicare Costs

Claims of military officials to the House Appropriations Committee that care of dependents in military facilities is substantially less costly than in civilian hospitals has been challenged by the American Medical Association in testimony to a Senate Appropriations subcommittee. Witness for the

AMA was Dr. Hugh Hussey, a trustee of the association and professor of medicine at Georgetown University.

The issue came to a head when the House Committee, accepting Navy witnesses' information as accurate, recommended the Defense Department require dependents of military personnel to use military hospitals so long as such facilities are deemed adequate by Defense. This elimination of free choice, Dr. Hussey testified, may bring about a major change in the law and may have "undesirable consequences." Accordingly, he urged the Senate committee to write language negating the House Committee recommendation.

At closed House hearings held in April, Navy witnesses made these claims: Cost of dependent care in civilian hospitals is \$50 per day. For purposes of interagency reimbursements, cost of like care in military facilities has been set at an arbitrary \$27.50. As a result of these comparisons, the House Committee, in the interest of economy, decided that more use should be made of military hospitals.

Following testimony of a Navy witness that medicare in civilian facilities would cost from two to two and one half times more than similar care in military hospitals, the House Appropriations Committee made the following report:

"It is the Committee's belief . . . that the free choice element (should) be amended so as not to permit dependents to utilize civilian medical and/or hospital services unless a positive determination is made by appropriate authority that, without augmentation, the military medical hospital facilities and medical personnel in the general area in which the dependents reside are inadequate . . . First, it will assist in utilizing military medical facilities at the optimum efficient level; second, it will continue to provide the needed medical care at lesser cost."

In his appearance before the Senate subcommittee on June 19 Dr. Hussey made the following points:

1. The House committee's recommendation is not warranted, because the cost figures on which it was based are inaccurate and, as admitted by the military, "there has been insufficient experience" to justify the firm estimates presented by the military.

2. According to the Bureau of the Budget itself, the \$27.50 per day set as the cost in military hospitals is a rough estimate, not taking into account a number of important cost items, including depreciation of buildings and equipment, outpatient care,

pay of interns and half the pay of residents, cost of recruitment, training and transportation. All of these or comparable items are used by civilian hospitals in computing dependent care costs.

3. When these costs are included, the Budget Bureau estimates the cost would be about \$36 per day in military hospitals. Even this total fails to include several cost items. "If a comparison is to be made of civilian and military costs," Dr. Hussey testified, "it must be made on the same type of case with the same factors used in computing the basic cost figure."

5. The claim advanced by the military that use of civilian facilities by dependents is resulting in overloaded hospitals in some areas cannot be supported; a survey of medical society officials and a check by American Hospital Association disclosed "not a single instance" of overcrowding, and Maj. Gen. Paul I. Robinson, head of medicare, himself testified he knew of none.

Many Projects in States Hit by Denial of Funds

Congress has abruptly terminated a modestly budgeted program that was just starting to pay dividends as a civil defense measure to State and local health departments, medical schools and hospitals throughout the nation. In sustaining drastic reductions made by House in funds for Federal Civil Defense Administration, Senate denied all sums asked for functions delegated to Department of HEW (also six other departments). As a result, Public Health Service can not contribute to MEND next year and consequently some kind of retrenchment may have to be made in this medical school curricular innovation which is in increasing demand.

In addition, PIHS must suspend technical aid to hospitals and other health facilities in such areas as research against biological and chemical warfare agents; stop recruiting for its commissioned reserve, or at least decelerate markedly, and put an end to special training of epidemiologists, sanitary engineers and others in State and local health departments.

Assistance to State by Food and Drug Administration, Office of Education and Social Security Administration also must end by June 30. Senate Appropriations Committee made it clear that Department of HEW is not to continue any of these emergency programs with its own funds: "Funds

recommended for the Department (of HEW) in this bill do not provide for any of the functions of the FCDA delegate agency programs, for which no estimates were considered by this committee in connection with the bill."

In other words, these popular civil defense training and research functions must stop even if a philanthropic foundation were to offer to pay the bill. In fiscal year just ending, Department of HEW spent total of \$2,340,000 in FCDA money on these programs and it was Administration's plan to raise this to about \$3.5 million in coming year.

NSF Reports on What Research is Costing Medical Schools

Medical schools in the U. S. spend about as much on research as for instructional purposes, according to a National Science Foundation survey of one recent year (1953-'54). The study covers 74 schools, 40 private and 34 public. Between 1941 and 1954 federal support of medical school research increased from less than \$1 million to \$22.8 million; because the U. S. medical research appropriations were approximately doubled for this fiscal year, it can be assumed that the federal contribution to medical schools now is greatly in excess of the 1954 figure.

Other points made by the report: Federal research assistance came from the following sources—HEW \$14 million, Army \$3.6 million, Navy \$1.3 million, Air Force \$1 million, Atomic Energy Commission \$2.1 million, NSF \$138,000 and other agencies \$179,000. From the period 1948 to 1954 non federal research support increased at about the rate for federal support, but this year's large federal increase has put the U. S. well ahead.

IRS Rules on Health and Accident Insurance

Internal Revenue Service has ruled (Rev. Rul. 57-229) that a health and accident insurance policy under which company reserves right to adjust premium rates in accordance with certain conditions and which is renewable at option of the insured does not constitute a noncancellable contract of health and accident insurance within meaning of Sec. 801 of Internal Revenue Code of 1954.

VA Formally Announces Policy Change on Compensation Cases

Following up its May 29 order to Veterans Ad-

ministration hospitals, the VA on June 26 formally announced to the public that nonservice-connected cases covered by workmen's compensation or similar accident insurance will be asked to move from VA hospitals when their conditions warrant. But no veteran will be transferred or discharged until his right to necessary treatment elsewhere at no expense to himself has been clearly established, VA said.

The order applies only to veterans who do not have a service-connected disability and are admitted for occupational injuries or diseases incurred in or as a result of their employment. Since most veterans brought to VA hospitals for on-the-job injuries are emergency cases, the extent of industrial accident insurance usually can't be determined until after admission, VA said.

Once this is determined, the veteran will be asked to reconsider his statement of inability to pay and to agree to a transfer. A veteran refusing in these circumstances will have his file sent to Washington for review and possible referral to the Justice Department for prosecution.

Health Care Price Index Rises With Other Items

Medical care, a term embracing hospitalization, drugs and all other health maintenance items along with physicians' services, holds top spot on consumer price index for May. Composite index for all consumer items is 119.6, compared with 119.3 in April (1947-49 = 100). Medical price index is 137.3, a rise from 136.9 a month earlier.

A brief research report by Social Security Administration (Division of Program Research) states that, in 1955, out of every \$100 of disposable personal income \$4.14 was required to pay for medical care. In 1948 the ratio was \$3.89 per \$100. Interesting sidelight: Despite great increase in hospitalization insurance coverage since 1948, out-of-pocket payments to hospitals have declined negligibly. Hospitals in 1955 were getting \$1.24 for every \$100 of disposable income: 62 cents from insurance and 62 cents direct from patients. This compares with 89 cents per \$100 in 1948, of which 24 cents came from insurance and remaining 65 cents from patients' pockets.

Social Security Resolution

Rep. Albert Cretella (R-Connecticut) has presented to the House a referendum from the Con-

necticut State Medical Society showing a majority of physicians replying favored being brought into the social security program on a compulsory basis; it was referred to the House Ways and Means Committee.

Library of Medicine Policy on Lending to be Changed

A major policy change in the lending activities of the National Library of Medicine goes into effect September 1. On that date, the library will no longer lend materials to individuals "over the counter" for use outside the building. However, it will continue its interlibrary service and photoduplication service in order "to get medical literature to all who need it anywhere." Requests from individuals will be channeled through other libraries, and no requests for loans of original works or photocopies from individuals will be honored. The NLM will decide whether to fill interlibrary loans by sending the original or furnish microfilms or photoprints.

Such a system, should take a large amount of pressure off regional medical libraries and will be cheaper for the borrowing library, NLM said. "In carrying out the program in this manner, the National Library of Medicine believes it is fulfilling its obligations to serve all people impartially . . . and to strengthen other medical libraries of the nation."

Gerald Gross Prophecies

It is now only a question of when White House will announce appointment of Dr. Elmer Hess of Erie, Pennsylvania, former president of AMA and chief of "Doctors for Eisenhower" in 1956, to succeed Dr. Howard A. Rusk as chairman of Health Resources Advisory Committee.

Medicare

Letter No. 16 of July 10, 1957 from the Office of Dependents' Medical Care of the Department of the Army, is of interest to all physicians:

1. EMERGENCY CARE (REFERENCE JOINT DIRECTIVE)

Misinterpretations concerning the types of emergency care authorized under the Dependents' Medical Care Program appear to exist in various areas throughout the country. It is the intent of the following discussion to clarify the emergency care

aspects of the program in order that any erroneous misinterpretations can be corrected.

Acute emergency care of any nature in a hospital is covered under the program. Such emergency care for an illness or condition not otherwise covered is only authorized pending arrangements for care elsewhere. (Paragraph 502 g of Joint Directive.)

When admitted to a hospital for emergency care the medical facility to which admitted need not meet the definition of a "hospital" as stipulated by the Joint Directive (paragraph 601 a.). However, this does not eliminate the requirement for admission as an inpatient to a medical facility for 18 consecutive hours or more except for shorter periods of hospitalization for surgical procedures, treatment of fractures or other bodily injuries, or in instances in which death occurs in a lesser period of time. (Paragraph 503 b of Joint Directive.)

Consequently, emergency treatment is not in itself sufficient grounds for inclusion within the Dependents' Medical Care Program.

Essentially, the Dependents' Medical Care Program is an inpatient program providing for outpatient care only in the following areas:

1. Obstetrical and Maternity Services (paragraphs 502 d and 503 d(2)).
2. Bodily Injuries, limited to the treatment of fractures, dislocations, lacerations and other wounds (paragraphs 502 f and 503 d(3)).
3. Diagnostic Tests and Procedures prior to and/or following hospitalization for the same bodily injury or surgical procedure for which hospitalized (paragraph 503 d(1) (d)).
4. Radio Therapy prescribed during a period of hospitalization and continued or carried out on an outpatient status (paragraph 2 of ODMC Letter No. 3).

Irrespective of the existence of an emergency the above constitutes the only areas in which outpatient care can be authorized under the program.

In view of the foregoing, emergency care to be payable by the Government under the Dependents' Medical Care Program must be either:

1. Outpatient care as stated above which is normally provided for under the program; or
2. Care furnished to a patient who is admitted to a hospital as an inpatient irrespective of whether the hospital meets the definition of a "hospital" as defined in the Joint Directive.

(Continued on Page 779)

OBITUARIES

William Francis Verdi, M.D.

1872 - 1957



"More is thy due
Than more than all can pay"
Macbeth
Act I, scene 4

Early on Easter Sunday afternoon, April 21, 1957, Dr. William F. Verdi passed away at his home in New Haven. In November, 1951 he was stricken with apoplexy, and has been confined most of the time since to his bed. Fortunately during that long period he suffered little pain, and the cerebral damage was such that he never realized his condition, or the circumstances attending his illness.

Born in Italy, he came to America when he was not quite two years old. His parents settled in New Haven, and it was here Dr. Verdi spent his life. He attended the primary schools, and in 1891 graduated from Hillhouse High School.

Strongly encouraged by the principal of the high school he entered Yale Medical School. Graduating in 1894, as the course at that time was three years, he and Horst Oertel who was a classmate went to Berlin and spent the next year in the study of pathology and surgery under Virchow and other

noted Germans of that time. Oertel later succeeded Adami as professor of pathology at McGill.

After some 14 or 15 months in Germany, Verdi returned to New Haven and opened an office for the general practice of medicine and surgery, which was the custom in those days. Then began a career unequalled in the annals of medicine in the State of Connecticut. His success was remarkable and instantaneous. Within a few years his reputation as a surgeon spread over the lower part of the State, and not long after over the entire State. All surgery of that time, especially that of private patients, was done in the home, as both hospitals in New Haven were closed institutions. This meant laborious preparation in the kitchen or any other available room in the home. The surgeon brought his own table, his instruments, and all other necessary articles connected with an operation, and the event consumed most of the day.

Occasionally, down through the years, a few friends would gather with him, and his reminiscences of those days, his disappointments, struggles and obstacles to be overcome, were nights of absorbing interest. Almost every type of surgery was done: abdominal, intracranial, chest, radical neck dissections, amputations, plastic repair; even mastoid and eye enucleations. Nothing was evaded.

This home surgery was continued until 1907, when, with a small group of other physicians of New Haven, and with the approval of Bishop Tierney, the Sisters of Charity of New Jersey were prevailed upon to come to New Haven and start a hospital that would be open to all practicing physicians. This was the start of the Hospital of St. Raphael to which Dr. Verdi remained closely attached all his life. In fact, the two were synonymous.

The long period of apprenticeship in the homes made him self reliant and increased his confidence. As candles, oil lamps and gas were the only means of illumination, chloroform had to be the anesthetic of choice, as ether could not be used near an open flame. These two were the only anesthetics in use then.

When the hospital finally opened he forged ahead rapidly. His surgery was daring in that day. Often when asked to what special field of surgery he con-

fined his efforts, his reply was, "everything under the skin." I recall having assisted him in a total gastric resection in 1912, and shortly thereafter in a resection of the Gasserian ganglion. He was an expert diagnostician, not only in surgery, but in medicine as well. Many of his colleagues thought he had eyes and ears in his fingers, for it was an education to see him examine an abdomen. His work was clean, incisive and direct, with no lost motions. As a gross pathologist he was without a peer. Five or six major operations was the usual daily routine, month after month and year after year. For the first thirty years of this century he worked in almost every hospital in the State, with the possible exception of lower Fairfield County, and up to the last decade of his life his work day was from 14 to 16 hours.

He was most generous with his time and money and skill. He loved his work, and never thought of pecuniary reward; his compensation was the patient's complete recovery. He took great joy in seeing a desperate case make the grade, and often called in his medical friends to examine the patient and share his pleasure.

Perhaps the writer errs in his adulation of Dr. Verdi, but his opinion has been shared by many others that Dr. Verdi was supreme in surgery in Connecticut for many years, especially in the period from 1900 to 1940. His reputation was also international, for he had patients from the middle west, Mexico, Peru, and Italy. John B. Murphy of Chicago thought well of him, as did the Mayo brothers. Both visited him in New Haven. Our own beloved George Blumer, with whom he was associated many years, ranked him high as a diagnostician.

He served in the first World War with the rank of major, and was stationed in a base hospital in France. Here his work in chest surgery was outstanding, and for this he was honored by Congress. After peace was declared he returned to practice, and then began a long and most active career in surgery. He planned for a greater hospital, and slowly but carefully nurtured ideas that finally came to fruition in the enlarged St. Raphael's, which he lived to see completed.

This extreme activity prevented him from writing much in medical literature. Medicine is poorer because of this. His experience was so vast and so varied it is a pity he did not record it for posterity, for he had much knowledge to impart. Those of us

who were with him constantly were able to pick up many pearls of wisdom which would have been so beneficial had they been recorded.

Dr. Verdi was the recipient of many honors during his lifetime. At various times he was president of the New Haven City, the New Haven County, and the Connecticut State Medical Societies. For many years he was the only member of the American Surgical Association from Connecticut. He was also a member of the American Urological Society.

The Congressional Medal of Honor was granted to him for his services in the first World War. From 1910 to 1914 he was surgeon-general on the staff of Governor Simeon Baldwin of Connecticut. Governor Wilbur Cross appointed him a member of the Commission which repealed the Eighteenth Amendment. He served several terms on the Board of Education in New Haven, and for the past fifty years was a corporator and trustee of the Connecticut Savings Bank of New Haven. In 1939 he received the award of the New Haven Advertising Club for meritorious service to the City of New Haven. King Victor Emanuel of Italy honored him on three occasions; first as Cavalier of the Crown, second as Commendatore, and finally as Grande Officiere, the highest honor within his power to grant.

From 1895 to the time of his death he was associated with Yale Medical School. He was demonstrator, then instructor in anatomy; assistant professor of obstetrics and gynecology; clinical professor of surgery, active and then emeritus. In 1914 his Alma Mater conferred an honorary Master of Arts degree upon him. He was also a fellow of Branford College.

The position of which he was most proud, however, was that of surgeon-in-chief of the Hospital of St. Raphael, which he held for fifty years. This fine and modern institution, the result of his years of untiring efforts and devotion, is his monument. He spent his happiest moments within its walls, along with those friends and colleagues who were so devoted to him, and of whom he is the last. His death almost closes the ranks of that great group of men famed in the art of clinical diagnosis; men who exercised to the full those Divine gifts of observation, palpation, percussion, auscultation, and, above all, deduction.

Charles T. Flynn, M.D.

Charles Williams Comfort, M.D.

1885 - 1957



Charles Williams Comfort, soldier, physician and long time officer of this Society, died on May 6 at the State Veteran's Hospital, Rocky Hill, after an illness of two months following a heart attack. With his passing Connecticut medicine lost one of its most colorful and interesting figures. Charlie Comfort was born in Philadelphia July 3, 1885 and was educated at Hotchkiss School, Lakeville, Yale College and Yale Medical School from which he received his M.D. in 1911. He was an intern at the Norristown Hospital, Pennsylvania and the New Haven Hospital. A well trained, competent and beloved physician, he was built to be a soldier.

Colonel Comfort's military life began almost by chance in November, 1914 while he was an intern at the New Haven Hospital and was commissioned a lieutenant in the Medical Corps of the Connecticut National Guard. It was the start of a career that lasted for 35 years until he retired in 1949 at which time he declined promotion to a brigadier general and would not accept retirement pay. In 1916 he was in Arizona in the now almost forgotten Mexican Border episode when General Pershing was pursuing Pancho Villa. Then home for a few weeks and mustered into federal service again on June 18, 1917. To France October 3 and on December 6 he was transferred from a field hospital to the 102nd Infantry as surgeon although still a lieutenant. He did not become a captain until September 1918 but

served continuously as Regimental Surgeon. He was always in the thick of combat and his charmed life carried him through most of the major engagements on the American Front and brought him many decorations, none of which are mentioned in the brief autobiography that he wrote for the History of the Medical Profession of Connecticut in the World War. He was certainly the outstanding medical officer from New England and for a time his name was legendary. Upon his return to New Haven a major in 1919, he was widely supported as a hero candidate for mayor of the city, somewhat to his embarrassment.

Home again and back to medical practice but soldiering was in him. He was commissioned lieutenant colonel and colonel and reorganized the Medical Department of the Connecticut National Guard, commanded the 118th Medical Regiment which was officered by many of his old comrades in arms. He became Surgeon General of the State and was elected president of the Association of Military Surgeons of the United States.

At the beginning of World War II he was the ranking National Guard medical officer and served in many posts in the United States. Some of these assignments may have bored him for although he was always in the Medical Department he was a skillful tactician and student of logistics and combat science and wanted to be where something was happening.

This was all a fine career but he liked to do things and in 1920, a year after coming home from France, he succeeded John Lane as secretary of the Connecticut State Medical Society, an office that he painstakingly held for seventeen years until the operation of the Society was reorganized and he voluntarily withdrew. During these years he maintained the old tradition and meticulously edited the *Transaction of the Society* which will be an everlasting monument to his unselfish service to the medical profession.

Through the years Colonel Comfort worked diligently for an adequate infirmary for troops at the State Military Reservation at Niantic. These efforts finally came to handsome completion and the hospital is named for him. Along the way he had time to serve on the Welfare Board of the City of New Haven and did many great kindnesses for the people of the community which are unrecorded and understood only by his friends. The flag that draped his casket now flies at Springside, the City

Home and Hospital for aged and indigent that Charlie helped to plan.

"None knew him but to love him. None named him but to praise."

Creighton Barker, M.D.

John Daniel Donohue, M.D.

1885 - 1957



Dr. John Daniel Donohue died at his home on May 13, 1957 after a long illness. He was born February 24, 1885 in Frankfort, New York, the son of Dr. John J. and Sarah Neill Donohue. He attended the grammar school in South Windham and graduated from Windham High School in Willimantic after which he continued his preparation for medical school at Niagara University, graduating in 1905. This same year he entered Baltimore Medical College, now the University of Maryland School of Medicine, from which he graduated in 1909. He was a member of Chi Zeta Chi Fraternity.

Dr. Donohue interned at the New York Lying-In Hospital one year and served as house physician at St. Vincent's Hospital in Bridgeport the following year.

During World War I, Dr. Donohue served as a Medical Officer in the Merchant Marine. Following his discharge he came to Montville and had practiced there for 39 years. In January, 1937 he was appointed health officer, town physician, and medical examiner. Later, on becoming school physician, he worked diligently to make the school health

program an efficient and successful department of the local school system. He was a member of the Knights of Columbus for many years. Dr. Donohue was highly respected by his many patients and loved by the school children among whom he worked with infinite patience and understanding. The good doctor will be remembered and missed for a long time.

H. Norman Rasmussen, M.D.

William F. Reardon, M.D.

1886 - 1957



Dr. William F. Reardon, West Hartford, Connecticut, died March 29, 1957 in his seventy-first year. His death followed a prolonged illness which had disabled him during the last three months of his life.

Dr. Reardon was born August 10, 1886 in South Windsor. He was graduated from St. Bonaventure's College, Alleghany, New York and continued his studies at the Baltimore Medical College, receiving his medical degree in 1909. Returning to Hartford, he served as intern at St. Francis Hospital in 1910. His internship completed, he took up the advanced study of diseases of the ear, nose and throat in Vienna and Berlin. Returning to Hartford in 1912 he engaged in the practice of otolaryngology which he followed until the time of his death. He served for many years as an attending otologist to St. Francis Hospital, Hartford. His membership in numerous medical societies included Fellowship in the American College of Surgeons.

Dr. Reardon was a well trained doctor with a deft pair of surgical hands. His interest in his medical work prompted him to devote a great deal of time and thought to the physiology and pathology of the function of hearing and he left an unpublished manuscript of more than one thousand pages containing his investigation of this subject. He had a lively interest in town government and served several terms as a member of the Town Council in West Hartford as well as Chairman of the Zoning Commission and a member of the Board of Health. His knowledge of town government was broad and accurate. A natural athlete, he was a finished golfer, a great golf companion and on occasions played par golf. He saw active service in World War I as a lieutenant in the Medical Corps.

Dr. Reardon is survived by his wife, Mrs. Josephine Many Reardon, a son William F. Reardon, Jr. of Redding, a daughter Mrs. Barbara Talcott of West Hartford, and four grandchildren.

Edward J. Whalen, M.D.

Arthur M. Yudkin, M.D.

1892 - 1957



With the death of Dr. Arthur M. Yudkin, May 2, 1957, Connecticut lost one of its leading ophthalmologists. Dr. Yudkin was well known, not only for his extensive practice, but also nationally and internationally for his work on nutrition in con-

nection with the eye, particularly in regard to vitamins.

Dr. Yudkin was born in Ansonia, on December 31, 1892, the son of Michael and Minnie Zandler Yudkin. He was graduated from Yale Sheffield Scientific School in 1914 with a Ph.B. degree, and received his M.D. from Yale Medical School in 1917.

He was assistant resident physician at New Haven Hospital from 1917 to 1918 and was intern in ophthalmology in 1918. Following this he was clinical assistant in ophthalmology and laryngology in the Yale School of Medicine until 1921, and for the next four years he was clinical instructor in ophthalmology.

He was assistant professor at the School of Medicine in 1925, becoming clinical professor of ophthalmology in 1934, a position he held at the time of his death.

Dr. Yudkin was attending surgeon in ophthalmology at Grace-New Haven Hospital, attending ophthalmologist at the Hospital of St. Raphael, and consulting ophthalmologist at Griffin Hospital, Derby, and at Bristol Hospital. He was also consultant to the National Society for the Prevention of Blindness.

In 1943 Dr. Yudkin was commissioned a major in the Medical Corps Reserve. He was a member of the American Academy of Ophthalmology and Otolaryngology, American Ophthalmological Society, National Society for the Prevention of Blindness, Society for Experimental Biology and Medicine, New York Academy of Medicine, Society of Clinical Ophthalmology, Sigma Xi honorary society, Milford Yacht Club, Racebrook Country Club, and the Yale Faculty Club. He was coeditor of the Practitioners' Library of Medicine and Surgery.

Dr. Yudkin is survived by his wife, the former Adele I. Weissman of Woodbridge whom he married in 1920, and two sons, Marvin Yudkin of New Haven, and Dr. Gerald Yudkin of St. Paul, Minnesota.

Dr. Yudkin's life was devoted to his practice, his family, and home. On his last day he spoke at length of these three things. At the meeting he attended the afternoon before his death he discussed a paper on "Disease of the Optic Nerve," a subject in which he had an abiding interest.

A host of patients will remember him for his zeal, skill, and kindness.

Frederick A. Wies, M.D.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1956-1957

(Concluded)

REPORT OF REPRESENTATIVE TO CONNECTICUT HEALTH LEAGUE

Clement F. Batelli, Chairman

Sue T. Gould

S. Allison Rose

The Connecticut Health League held two meetings during the year, one on May 23, 1956 and the second the annual meeting on January 30, 1957.

I was not able to attend the first meeting in May. The agenda for this meeting included a panel discussion on "Tackling a Community Health Program"—Example: Fluoridation. The speakers were Harold Singer, D.D.S. of Torrington and Edward Bronstein, D.D.S. State Department of Health.

At the Annual Meeting in January the following State Officers were elected. President, Dr. Ira Beebe; Vice-Presidents, Dr. Alfred Burgdorf, Prof. Walter McKarin; Secretary-Treasurer, Dr. Harold S. Barrett; Directors to 1960, Dr. Sidney Shindell, Miss Gertrude Noreross, Dr. R. C. Edson; Members at Large, Dr. Alexander Tuttle, Dr. Alice Donnelly, Dr. Norton Chaucer, Dr. Alfred C. Burgdorf, Mr. Chester Bower, Mrs. Ira Hiseock, Mrs. Louis Condert, Dr. James R. Miller, Dr. Clement F. Batelli, Dr. Martha Clifford.

Several committee reports were given.

1. Committee on Coordination of Voluntary Health Agency Programs:

Recommended that the League look into the problems of persons who are chronically ill but whose conditions are such that they do not fit the eligibility requirements for rehabilitation. The Committee also discussed the need for expanding Homemakers Services.

Attorney Frederick Pope, speaker for the afternoon session, talked on the organization and structure of the Connecticut General Assembly, pointing out the procedures through which legislation is introduced and acted upon. He stressed the importance of citizen interest being reflected by qualified representation at public hearings, and the need to educate legislators about proposals.

The following persons spoke on behalf of legislation, before the current session of the General Assembly.

Dr. Sidney Shindell outlined a proposal on a loan fund intended to benefit persons of moderate means but economically above welfare status, to meet the cost of chronic illness on a long term installation basis.

Miss Frances Hartshorne and Dr. Elias March discussed the ten point program proposed by the State Department of Mental Health and its approval and support by the Connecticut Association for Mental Health.

Miss Jean Stair of the New Haven Visiting Nurses discussed a proposal for reinforcement to nursing agencies on a cost basis, to replace the present flat fee basis which is less than current needs.

Respectfully submitted,
Clement F. Batelli

REPORT OF THE ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Winfield O. Kelley, Chairman

Orvan W. Hess

Oliver L. Stringfield

Members of the committee frequently communicated with the members of the Woman's Auxiliary during the past year of considerable activity. Some of the health problems in the State were keynotes in the Auxiliary's program.

Consultation and advice have been available and given when necessary during the year.

Respectfully submitted,
Winfield O. Kelley

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

D. Olan Meeker, Chairman

Frank H. Couch

James S. Missett

Joseph A. Fiorito

Charles T. Schechtman

Henry Merriman

Alfred L. Burgdorf

Creighton Barker

With the closure of the 84th Congress many bills of far-reaching medical and social importance had been acted upon. The trend was toward the powerfully enforced Labor demands, not the demands of labor in many cases. Labor as spelled with a capital "L" is the philosophy of a few individuals imposed arbitrarily on many. Labor spelled with a small "l" is nothing else than what each of us does daily, whether with a stethoscope or shovel, or with shoulders or scalpel. And what is good for the capital "L" is often not fair to the small "l". The recent investigation of Mr. David Beck and his henchmen is only a prologue to the exposure of how far-reaching is the influence and debasement of the heads of many of our labor unions.

The last two years are clear evidence of the rapidly growing interest of our nation's lawmakers in the field of medicine. There were 571 bills in the health field during the two years of the 84th Congress, roughly 3 per cent of all bill introduced. Twenty-five of these were enacted. In contrast, in the 83rd Congress, 407 bills concerned the health field and 20 became law. In the 82nd Congress, only 250

health legislative bills were considered. In this 85th Congress it appears that bills concerning medical interests will amount to 5 per cent of all bills. Surely, Mercury is a man to watch.

The 84th Congress set a new high for money appropriated for health and medical programs. The budget for the 85th Congress is even higher.

Under the impetus of new legislation enacted during the last few years—and particularly the new emphasis on medical research—the federal health budget is rising steadily. Bills introduced in the present (85th) Congress seek to expand many existing programs or set up new ones. The following table gives the total federal health bill for the current and last fiscal year and a breakdown of health-spending for the top three departments of government.

	FISCAL 1957	FISCAL 1956	INCREASE
Total, all agencies.....	\$2,558,719,168	\$2,268,826,576	12.8%
Veterans'			
Administration.....	825,024,300	790,185,800	4.4%
Department of Defense	790,105,000	818,104,500	
Department of HEW	772,661,800	526,935,400	46.6%

The 84th Congress also introduced a new tax law under the guise of upping tax rates on so-called social security by including benefits for disabled workers at age 50. Let us look at a short history of so-called social security.

Of all the programs of government enacted in the last several decades, none has had greater impact on the population or has been subject to more liberalizing amendments than the Social Security Act of 1935. It began on a relatively modest scale, with retirement payments of up to \$10 a month for wage-earners who reached age 65. At that time, there were no benefits for the surviving spouse and children.

Now, 22 years later, the law has been amended to include: (1) survivorship benefits, (2) maximum monthly family survivorship payments as high as \$200, and (3) a program enacted in 1956 and effective this July 1 for payment of social security benefits to disabled workers at age 50. Efforts continue to be made to amend the law, including a program of free hospitalization of the aged, disability benefits at all ages, and compulsory national health insurance. Statistics on the program as it exists today:

- 9,250,000 persons received OASI monthly checks in January, 1957.
- 70,000,000 wage-earners are covered and being taxed; 9 out of 10 persons in the U. S. are primarily "insured" or are their beneficiaries.
- \$22,519,000,000 in U. S. bonds in OASI Trust Fund.
- Payments from the OASI Trust Fund and contributions to it are now about equal.
- Tax rate is 2¼ per cent for employees and employers (4½ per cent total); 3¾ for self-employed.
- Under present law, 1975 rate will be 4¼ per cent for employees and employers (8½ per cent total); 6¾ per cent for self-employed.
- Under a 1956 law, permanently and totally disabled persons aged 50-65 can get payments equal to retirement payments.
- Over 1,000,000 inquiries already have been made for disability payments or "disability freeze;" about one half of the more than half a million formal applications have been approved.

Labor organizations propose a \$6,000 tax base on which contributions would be computed, instead of the present \$4,200 base.

Also under the so-called social security act is the public assistance program which was enacted in 1935.

Its basic purpose was to assist states in providing subsistence for destitute families. From the beginning, the states have contributed a portion of funds for the various categories of recipients. Federal appropriations 20 years ago were about \$209 million annually. Now they have increased more than seven-fold, so that the appropriation for the current fiscal year approximates \$1.5 billion. There are four programs: aged, blind, permanently and totally disabled, dependent children.

Until amendments last year, unspecified federal-state funds were paid out for medical services of the needy. An educated guess has been that between \$90 and \$100 million of federal money has been going into such medical payments. A more accurate estimate should be forthcoming as a result of the 1956 amendments. These amendments set up a new category of federal-state payments for medical care over and above the old subsistence payment limits, with medical payments going directly to the physician, hospital, druggist, clinic or nursing home. As of now 5,100,000 persons get monthly public assistance checks—medical costs included.

Under new law, direct medical payments are to be made in behalf of assistance recipients to physicians, nursing homes, hospitals, and for drugs. These direct payments will probably exceed \$200,000,000 and could reach \$300,000,000 by 1958.

Another vast program with high demands on the federal budget is that for veterans medical care. The policy of the Federal Government is that wartime veterans with service incurred disabilities are entitled to the best medical and hospital care that can be provided. The American Medical Association supports this policy. Congress in June 1924, authorized VA to admit indigent nonservice connected veterans when there were spare beds. By 1957 roughly 75 per cent of all cases treated in VA hospitals were for injuries and diseases not originating during or aggravated by military service.

Now the problem is becoming more complicated as the veteran population grows older (World War I veteran in VA hospitals averages age 62) and becomes subject to chronic illnesses. Demands increase for use of VA facilities. Today VA requires: a full-time staff of over 4,600 physicians; 2,247 residents; 11,000 part-time consultants; and thousand of doctors on a contract basis for the agency's home-town care program. Here are some figures:

- 22,599,000 total number of living veterans as of January, 1957.
- 121,865 total number of VA hospital beds as of January 1957.
- 111,540 number of patients in VA hospital facilities on an average 1957 day.
- \$619,614,000 will be spent by VA for in-patient care in fiscal year 1957.
- \$82,638,000 will be spent for out-patient care in fiscal year 1957.
- More than 2 out of 3 veterans treated in VA hospitals are treated for nonservice connected conditions.

Let us next consider the potential beneficiaries of federal medicine.

Some of the greatest activity in the health field has involved laws and amendments to laws that widen the scope of medical care for federal beneficiaries. The very latest is Medicare voted last year for military dependents. Today nearly one out of every four persons, including over 22 million veterans, is eligible to receive at no cost to them some degree of medical care from the Federal Government. A rundown reveals:

- 22,599,000 living veterans as of January 1, 1957.
- 5,200,000 military personnel and their dependents.
- 300,000 beneficiaries of the Public Health Service, including 200,000 seamen, but excluding beneficiaries of Federal Employees' Compensation Act and Indians.
- 5,100,000 public assistance recipients.
- 370,000 Indians and Alaskan natives receiving care in 56 federal hospitals or in private facilities under contract.
- 4,000,000 beneficiaries of the Federal Bureau of Employees' Compensation Act (at-work injuries only).
- 48,627 PHS hospital admissions in 16 hospitals in 1956.
- 1,042,000 out-patient visits in 121 PHS out-patient facilities during 1956.
- Foreign Economic Aid Programs (entirely U. S.) and the World Health Organization (U. S. largest contributor) gave limited health care in 92 foreign countries. Example: 25,300,000 children were vaccinated in 1956.
- 7,000,000 federal employees and their dependents (will be eligible for health care if proposed legislation is enacted).

As opposed to this rising tide of medical socialism there is one outstanding bulwark—voluntary health insurance.

Twenty years ago the number of persons covered by some form of health insurance was only 1.5 million. When the drive was on for compulsory health insurance in 1949, just over 50 million persons were covered by voluntary insurance. Organized medicine contended then that voluntary coverage would expand, thus obviating the need for government insurance. The figures below prove this was a good estimate of the situation.

- 110,000,000 persons now covered for hospital charges.
- 92,000,000 persons now covered for physicians' charges for surgery.
- 55,000,000 persons now covered for physicians' medical charges in hospitals.
- 10,000,000 persons now covered for physicians' home and office call charges.
- 10,000,000 persons now covered for major medical expenses (catastrophic) compared with 1,200,000 covered in 1953.

These figures loom as a beacon in the lowering sky of medical socialism. They show that the average American, torn between semantic phrases which confuse him, unable to understand why he must strive to support a government and still prevent it from taking care of what he rightly believes is his own business, has yet in his mind a determination to fend for himself.

It behooves us to remember that no one will watch out for our status. Health, sickness, government care, government hospitals are inviting phrases with which to intrigue voters. You need only to look at what happened in Germany under Bismarck and later the Weimar Republic or to what

is happening now in England to realize that doctors and all they connote can easily become tools of government.

It is up to us to stop our complacency and become vocal, influential citizens in our own communities if we wish to avoid medical socialism.

With this report your chairman ends tenure of office. The years spent in this work have been provocative and enjoyable. Enjoyable mainly because of the whole-hearted support and help of Dr. David Allman, president elect of the American Medical Association, Dr. Thomas Murdock, our beloved trustee of the American Medical Association, Dr. Creighton Barker, our ubiquitous secretary, our Council and its chairman, Louis Fincke, also Dr. Oliver Stringfield, Dr. Ralph Ogden, Dr. Harold Marvin, Dr. Stanley Weld, Dr. Cole Gibson, Dr. Don Corridon, Dr. Thomas Danaher, and Dr. William Dobbs. My heartfelt thanks to all of them for their individual and concerted support on the many occasions where what to do next was cryptic.

The Committee on National Legislation has at all times faithfully fulfilled the onerous duties incumbent upon them on occasion. All of them have helped make a tedious job more cheerful.

Respectfully submitted,
D. Olan Meeker

REPORT OF THE COMMITTEE ON STATE BLOOD BANK

John E. Thayer, Chairman

Roy N. Barnett	Christie E. McLeod
Henry N. Blansfield	Sawyer E. Medbury
Joseph O. Collins	David T. Monahan
Theodore S. Evans	Paul D. Rosahn
Frederick B. Hartman	Clair Rankin
C. Henry Huvelle	Victor G. H. Wallace
Rolf E. Katzenstein	Levin Waters
Ralph E. Kendall	Ira V. Hiscock

The Committee on State Blood Banks is established "to promote the development of a state-wide blood bank operating in the interest of the people and the medical profession . . ." This, in practice, breaks down into three main categories.

First: The responsibility that the actual blood banking procedures are of the best, and fulfill all requirements of National Institute of Health Regulations, and that such requirements are met in all donor and recipient blood stations throughout the state.

Corollary: That when conflicts of interpretation arise with these regulations and the regulations of the Connecticut Regional Blood Program as such, that the Committee on State Blood Banks is available to set up an operating procedure in the indonor and/or recipient stations that will best enable such stations to function properly and economically.

Second: Consultation with the actual Blood Bank of the Regional Blood Program to modify such regulations as to the distribution, recovery, and fractionation of recovered units of blood, and the distribution of such fractions.

Third: Though not least, consultation with procurement agencies which, in this state, are primarily the American National Red Cross.

The committee met as a whole on June 5, 1956, and December 12, 1956, and early in March 1957 (after this report went to press) for discussion of the following points:

(1) A review of Blood Banking in Connecticut and the development of the State-wide Program which is well covered in the last annual report of this committee, in order to plan the general course of further development.

(2) The problem of supply of blood, especially the increased outdating of whole blood which contributes to state-wide shortages.

(3) The excessive use of "O" blood.

(4) Changes in requirements for the processing of blood, as required by the National Institute of Health.

(5) Future financing of the Blood Programs.

(6) Relative deficiencies or proficiencies in procurement of blood in various localities in the state, and possible corrective measures.

The state society has been informed of our findings in these problems as the problems arose, by copies of the minutes of these meetings. It was also felt that certain of such deliberations might well receive further distribution, and that two news letters be sent to members of the state society on specific subjects, yearly. At present, the subjects of greatest importance are the enlisting of the aid of all physicians in the procurement of blood and the warning of physicians on the indiscriminate use of blood. Perhaps the latter is well illustrated by a recent advertisement in the January *Texas Medical Journal* by the Texas Society of Pathologists, which I quote:

"This One Will Kill You—The Human Factor.

The human factor is killing your patients. Over three thousand people died in 1953 from blood transfusions of the wrong blood. More deaths from blood transfusion than from appendicitis, more than from all anesthesia. The wrong blood—the right patient; the right blood—the wrong patient. Why was the wrong bottle used?

Studies show that less than 10 per cent of the mistakes were due to technical inaccuracies in the laboratory. Over 90 per cent were due to the 'human' element—the Human Factor. The blood type and group were matched carefully, then someone used the wrong pint. The technologist issued the wrong bottle, or the nurse went to the wrong room, the intern didn't check the name tag, the attending physician didn't make sure of the label. 'Read the label before you stick that vein.'

Yes, our science is ahead of us. And this in the face of more blood being used. Unnecessary transfusions may spell death. One medical audit study of the abuse of transfusions showed one-third to be in error—given without sufficient indication or not given when indicated. Blood is now being given at the rate of ten pints per hospital bed per year—and this is going up. This isn't necessarily a bad sign, but it means we must be alert to dangers. Blood banks that keep a careful check show a 5 per cent reaction rate—major and minor reactions.

BEWARE AND BE AWARE

1. Give blood for serious need only. Ask yourself—Is this pint necessary?

2. Don't order blood as a 'little spring tonic'—for minor

indications. It is not only potentially dangerous but is an 'Expensive Meal.'

3. Support strict blood bank regulations and these will support the life of your patient.

4. Personally check the label of the blood for your patient.

5. Give blood before and after surgery—not during surgery (except for real emergency).

Remember—the life that the wrong blood takes may be your own!"

In brief, the answers to the main questions raised above are given here.

(1) and (5). More blood and its products will be used. The present facilities of the State Blood Bank may be recalled presently. The American National Red Cross is withdrawing financial support of blood programs. The cost of processing of blood is steadily rising. Therefore, plans must be made for an independent center which will function at cost of processing and consultative service for the whole state. Such plans must include the continued cooperation of procurement agencies so that the actual cost of blood be not added and the expansion of facilities for obtaining such professional services as arise, and the location of rare specific group-types as and when they are needed. We believe this program is being properly developed.

(2) The "outdating" of whole blood is handled, at present, by attempts at local redistribution of specific types and charging for outdating of units in excess of 200 units per year. This protects the small hospital and does not penalize the large hospital.

(3) The excessive use of "O" blood is felt to be due to incomplete control of bank facilities by responsible medical personnel or what might be poor management. Individual studies of individual recipient banks is needed to solve this problem and is being carried out, although, since such an inspection must be cooperative, it is seemingly slow.

(4) Changes in requirements set up by the National Institute of Health were met.

(6) Is still a current problem, and a specific meeting is being held for this purpose after this report goes to press.

It is felt that the problem of a State Blood Bank is still, and will be with us as long as we are dealing with humans as individuals, and that the medical profession must exercise a continuing consultative and controlling function, and that the Committee should continue as established.

Respectfully submitted,
John E. Thayer

REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

George A. Buckhout, Chairman

Egbert M. Andrews

Francis D. T. Bowen

Joseph J. Bruno

Francis J. Kalaman

Andrew P. Owens

Samuel B. Rentsch

Roy V. Sanderson

Benjamin M. Shenker

This Committee has seen a slow change in the emphasis and scope of its duties over the past 10 years.

When new, there were many veterans' problems to be ironed out. Much more care was directed to the Home Town Physicians. Now most of the work in Connecticut is done in V.A. Hospitals or Clinics. It still should be emphasized, however, that the Veteran Care program can never be allowed to bog down, and that all physicians should continue interest in the field.

Your Committee looked into and with the help of the specialty groups, revised the entire Schedule of Fees for Care of Veterans. This revision was forwarded to the Veterans Administration Headquarters in Washington, D. C. Their acceptance or changes in the revision will be published when received.

By vote of the Council of the State Medical Society, the Medical Advisory Committee to the Veterans' Home and Hospital, was dissolved and its duties taken over by this Committee.

A meeting was held in that hospital, in October 1956, and General Watt kindly conducted a tour of the entire plant.

The Council in their December 20, 1956 meeting, instructed this Committee to act as a "Special Committee" to work with our National Legislators toward passage of laws preventing the admission to V.A. Hospitals of patients with nonservice connected disabilities.

Respectfully submitted,
George A. Buckhout

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE STATE WELFARE DEPARTMENT

Edwin R. Connors, Chairman

Ettore F. Carniglia	J. Harold Root
Mark A. Gildea	Edwin F. Trautman
Maxwell Lear	William H. Upson
Donald R. Morrison	Harold D. Von Glahn
Leonard Parente	Harold F. Pierce, State Dept. Welfare, ex officio

It was necessary for this committee to meet but twice in the last year, since most of the "groundwork" for the principal function of the committee was done in the previous year, the Revision of the Fee Schedule for the Welfare Department. On October 31, 1956, the New Fee Schedule was approved by the committee and administration problems, consultations with the concerned professional associations and acceptance by the Commissioner of Welfare and the Commissioner of Finance and Control used up a period of four months, bringing the effective date to March 1, 1957. The committee is especially indebted to Dr. Harold F. Pierce for doing most of the "leg work" in the formulation of this schedule. It is the hope of the committee that members of the Healing Arts and Allied Professions will read the instructions and comply in as far as is possible to the regulations contained in the fee schedule.

The committee on two occasions were asked for advice by the Welfare Department, in cases of questionable practice, and in each case it was the recommendation of the committee that the Medical Director deal directly with the County Medical Association. One county association co-

operated, with the resolution of the problem, the other failed to take any action.

One of the members of the committee resigned during the year as he moved to New Mexico and the committee lost a conscientious and hard worker in Dr. Henry Louderbough. Although there have been but two meetings of this committee during the year much work has been done by individual members of the committee, on request of the chairman, at odd times and attendance at the meetings held was excellent. It is therefore a pleasure to thank each member of the committee for the good work done.

Respectfully submitted,
Edwin R. Connors

REPORT OF DELEGATES TO CONNECTICUT NUTRITION COUNCIL

Max Caplan

Robert R. Levin

The Connecticut Nutrition Council has had five executive committee meetings this year. There has been a substantial increase in its membership as various organizations realize the values inherent in the mutual exchange of ideas in nutrition. Several members have contributed articles on nutrition studies performed in Connecticut to the United States Department of Agriculture in Washington, D. C. which have been very well received, and which are subsequently scheduled for publication in *Nutrition Committee News*.

Delegates from this council were appointed to the Connecticut Health League and to the Connecticut Advisory School Health Council. A joint meeting between the Connecticut Society of Gerontology and the Connecticut Nutrition Council was held on October 24, 1956 at the University of Connecticut. The subject, "Eating for Health and Happiness in Later Years" was a very popular one, since more than 150 attended. After the conference, an evaluation questionnaire conducted by members of the Connecticut Nutrition Council showed that more than 100 of the participants felt it was very worth while.

The Council was requested to send to the Household Economics Research Branch, U.S.D.A. Research Administration, Washington, D. C. information helping the young people, particularly teenagers, in their food habits. This information on work done by the schools, scouts, 4-H or other youth organizations was compiled by the Chairman, Mrs. Martha Fry, and sent to Washington. The Committee on Family Nutrition is now preparing a series of articles for the newspapers, radio and television. These articles relate to prenatal, dental, children's food habits, teen-age nutrition, family nutrition, and gerontology and are being prepared by experts in these fields who are members of the Council.

On May 20 and 21 the tenth anniversary of the Connecticut Nutrition Council, a joint meeting is being planned with the nutrition councils of all the New England States. These meetings which will be held at the Hotel Bond in Hartford will be open to the public and will have as their theme: "Moving Ahead With Nutrition Education." Work shops, panel discussions, and talks are being planned

and the featured speaker will be Dr. Norman Joliffe, one of the first speakers to address our Council ten years ago.

Respectfully submitted,
Max Caplan

REPORT OF THE COMMITTEE ON EMERGENCY MEDICAL SERVICE

Benjamin B. Whitcomb, Chairman

Alfred L. Burgdorf	Samuel Spinner
Andrew J. Canzonetti	Francis P. A. Williams
Luca E. H. Celentano	C. Frederick Yeager
Francis Gallo	Henry M. Young
James R. Glessner	James C. Hart
Franklin M. Goodchild	Mrs. Helen Cullen
Edward H. Kirschbaum	Mr. Stuart W. Knox
John C. Larkin	Frederic S. Harold, D.D.S.

Mr. Felix Blanc

Your Committee on Emergency Medical Service has had one formal meeting with the adjunct members representing associated professional organizations present since the last meeting of the House of Delegates. A report on the course of Civil Defense given in Battle Creek, Michigan by the Civil Defense Organization was given by Dr. Gallo, and action was taken on several points of cooperation requested by the State Department of Civil Defense. Some of these matters were referred to the Council of the State Medical Society which resulted in the following essential actions: that the present Committee on Emergency Medical Service be available to the State Office of Civil Defense to advise in casualty planning in the field of civil defense in medical and health services. Secondly, it was requested by the Council that the Committee on Emergency Medical Service make recommendations to the Council as to the membership of the Casualty Planning Committee. Thirdly, this committee recommended that the County Societies reappoint county committees on disaster and that the state committee be notified of the chairmen of these county committees and that these committees cooperate and participate in exercises associated with the emergency hospital units. The Council of the State Society has brought these recommendations to the attention of the various county associations. The Hartford County Society has already complied with this recommendation.

Members of this committee have met with the Chief of the Medical Services of the State Office of Civil Defense on several occasions for advice in matters of liaison with the State Society.

It is of interest that several hospitals throughout the state have completed their disaster plans which will directly involve our members serving on their staffs. This has been done according to plans of the Society and the recommendations of this committee.

In view of the changing functions in organizations, this committee recommended to the Council that the committee be discontinued and its remaining functions delegated to a new Casualty Planning Committee, the membership of which should be from the various specialties particularly concerned with disaster casualties and that such committee

serve as a medical advisory committee to the State Office of Civil Defense.

Respectfully submitted,
Benjamin Bradford Whitcomb

Note: The recommendation contained in the last paragraph of the report was approved by the Council on March 27, 1957 and the Committee on Emergency Medical Service was discontinued with the thanks of the Society for its operation during the past many years. A new Casualty Planning Committee will be established by the Council when the functions and purposes are clearly understood.

REPORT OF THE CONFERENCE WITH THE DENTAL ASSOCIATION

Brae Rafferty, Chairman

David J. Cohen	Camille H. Huvelle
Cornelius S. Conklin	Edward T. Wakeman

The Conference Committee with the Dental Association has continued to hold its occasional meetings. The subjects under discussion have been of mutual interest, but the most important feature continues to be the opportunity for contact between the two associations. Since the first of the year, there has been a change in the personnel of the committee on the dental side.

At present, there are no recommendations coming from the Conference Committee.

Respectfully submitted,
Brae Rafferty

REPORT OF THE PERINATAL MORBIDITY AND MORTALITY COMMITTEE

Roswell D. Johnson, Chairman

William K. Bannister	Louis Guss
Ronald S. Beckett	Winston C. Hainsworth
Martha L. Clifford	C. Stanley Hitchins
David J. Cohen	Charles A. Murphy
Joseph A. Fiorito	Charles H. Peckham
Robert L. Fisher	Andrew F. Turano

This year the Committee has gone through a period of change in which we have been seriously studying the best method of approach to the problems of perinatal mortality. Reductions in personnel in the State Department of Health have made it impossible for them to select cases of perinatal deaths throughout the State as they formerly did. It was formerly their practice to provide fifteen perinatal deaths for study at each meeting of the committee and the stated funds are no longer available for this purpose.

The local perinatal mortality committees have been asked to send in cases for study and review, but there has been understandably some reticence about freely referring cases to a State committee. Some committees have felt that their local staffs did not approve of this while in other cases the necessary time to send in an adequate summary was apparently not available to the committee members.

The supplement to the birth certificate has been revised after a request for consultation by the Bureau of Vital

(Continued on Page 779)

SPECIAL NOTICES

PROGRAM—ANNUAL MEETING—DISTRICT I THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

September 27-28, 1957

Wentworth By-the-Sea, New Castle, New Hampshire

MORNING SESSION, FRIDAY

- 8:30 A. M. Registration
- 9:00 A. M. Panel—Cesarean Section
Dr. Nicholson J. Eastman, Baltimore, Maryland
Dr. R. Gordon Douglas, New York, New York
Dr. Duncan E. Reid, Boston, Massachusetts
- 10:30 A. M. Coffee
- 11:00 A. M. to 12:30 P. M. Round Tables
1. Maternal Mortality
Dr. John F. Jewett, Boston, Massachusetts
 2. Ectopic Pregnancy
Dr. Daniel J. McSweeney, Brookline, Massachusetts
 3. Cancer of the Uterus
Dr. Langdon Parsons, Boston, Massachusetts
- 1:00 P. M. Luncheon

AFTERNOON SESSION, FRIDAY

- Presentation of papers
- 2:00 P. M. The Significance of Atypical Endometrial Patterns
Dr. Donald McKay, Boston, Massachusetts
- 2:30 P. M. Causes of Spontaneous Abortion
Dr. W. R. Carl Tupper, Halifax, Nova Scotia
- 3:00 P. M. Abnormal Bleeding
Dr. Robert W. Kistner, Brookline, Massachusetts
- 3:30 P. M. Diabetes in Pregnancy
Dr. Luke Gillespie, Brookline, Massachusetts
- 4:00 P. M. Heart Disease in Pregnancy
Dr. Sydney Burwell, Boston, Massachusetts

EVENING SESSION, FRIDAY

- 6:30 to 7:30 P. M. Cocktails—Fellows and Wives
- 7:45 P. M. Banquet—Fellows and Wives—Dress—Optional
- 9:00 P. M. Address
Dr. Nicholson J. Eastman, Baltimore, Maryland

MORNING SESSION, SATURDAY

- 9:00 A. M. to 10:30 A. M. Round Tables
1. Infertility
Dr. C. Lee Buxton, New Haven, Connecticut
 2. Bleeding Third Trimester
Dr. Arthur F. G. Edgelow, Springfield, Massachusetts
 3. Ovarian Tumors
Dr. Henry C. McDuff, Jr., Providence, Rhode Island
- 10:30 A. M. Coffee
- 11: A. M. Presentation of Paper—Endometriosis
Dr. Joseph V. Meigs, Boston, Massachusetts
- 12:00 NOON. Business Meeting
- 12:30 P. M. Luncheon
- 2:00 P. M. Golf and Tournament
No Green Fees—No Entry Fees
- Physicians in training are welcome to attend at sponsor's expense.
- Reservation blanks should be returned directly to Wentworth By-The-Sea.

Ladies' Program

FRIDAY

- 2:00 P. M. Historic Tour
- 4:45 P. M. Tea
- 6:30 P. M. Cocktails—Fellows and Wives
- 7:45 P. M. Banquet—Fellows and Wives—Dress—Optional

SATURDAY

- 10:00 A. M. Social Hour with Special Speaker
- 2:00 P. M. Golf and Tournament
No Green Fees—No Entry Fees

INTERNATIONAL CONGRESS OF INTERNAL MEDICINE TO MEET IN PHILADELPHIA IN 1958

The International Society of Internal Medicine has announced that its Fifth International Congress of Internal Medicine will be held at the New Sheraton Hotel, Philadelphia, Pa., April 24-26, 1958. This will be the first meeting of the Society outside of Europe. In making the announcement, the International Society's President, Sir Russell Brain, who is also President of the Royal College of Physicians of London, said "The Executive Committee of the Society has chosen the United States for its fifth Congress in response to an invitation extended by the American College of Physicians and with the objective of

securing greater American participation in its deliberations and of allowing foreign members, at first hand, to learn more about American developments in the medical sciences."

NEW HAMPSHIRE AND VERMONT JOINT MEETING

The Joint Annual Meeting of the New Hampshire Medical Society and the Vermont State Medical Society will be held at The Balsams, Dixville Notch, N. H., September 14-17, 1957.

TWENTY-SECOND ANNUAL CONGRESS

Twenty-Second Annual Congress of the United States and Canadian Sections, International College of Surgeons. Palmer House, Chicago, September 8-12, 1957.

THE CONNECTICUT ASSOCIATION FOR MENTAL HEALTH, INC.

The Connecticut Association for Mental Health, Inc., invites applications for research grants in amounts up to \$1,000, \$2,000, \$3,000 for projects concerned with mental health.

Projects may be in any related field, including psychiatry, psychology, social work, community work, education, and the basic sciences, such as neurology, neurophysiology, biochemistry, etc.

Research grants will be made for a period of one year.

Eligible: Persons working within the State of Connecticut.

Final date for receipt of application: October 1, 1957.

Awards will be announced on November 1, 1957. On-going as well as new projects will be considered.

Application forms may be obtained by writing to: Merle W. Mudd, Executive Director, Connecticut Association for Mental Health, 956 Chapel Street, New Haven 10, Conn.

MEDICARE

(Concluded from Page 776)

This eliminates from coverage emergency care, not related to an obstetrical or injury case, that is performed in a doctor's office or clinic.

2. GOVERNMENT LIABILITY IN OBSTETRICAL AND MATERNITY SERVICES

Two questions have been raised concerning the scope of obstetrical and maternity services for which

the Government is liable. Although varying terms are used in the Joint Directive, such as "obstetrical and infant care," "complete obstetrical and maternity care," and "complete obstetrical and maternity services," the governing limitation of the Joint Directive is the definition of Maternity and Infant Care (paragraph 103j (3)). That definition includes the provision "incident to pregnancy." Hence, outpatient "antepartum" care of pseudocyesis, or the outpatient administration of examinations and diagnostic procedures which lead to diagnosis that the patient is not pregnant, are not proper charges against the Government under Public Law 569-84th Congress.

Paul I. Robinson, Major General, MC
Executive Director,
Office for Dependents' Medical Care

ANNUAL REPORTS

(Concluded from Page 777)

Statistics and we hope that a certain skeleton of information will become more readily available.

The committee is now spending its time on a check sheet designed to lend itself to statistical analysis through IBM machines. This form must be sufficiently complete to contain information, it must be sufficiently brief so that the physicians will fill it out, and must be sufficiently clear in its questions that we can be sure the appropriate answer will be the same regardless of the hospital from which the report comes.

On April 3 and 10, the committee has arranged in cooperation with other professional groups in the State a two day program on "Recent Changes in Maternity and Infant Care" to be held at the Connecticut Light and Power Building in Berlin. Also cooperating with the State Medical Society are the Connecticut State Department of Health, Connecticut League for Nursing, Connecticut Hospital Association, Connecticut State Nurses Association, Connecticut Chapter of the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the Connecticut Society of American Board Obstetricians and Gynecologists.

The Stamford Hospital and the Middlesex Memorial Hospital have within the past year set up formal perinatal mortality study committees.

Respectfully submitted,
Roswell D. Johnson

AROUND THE STATE

New \$1 Million Lab to be Constructed at Yale Medical School . . .



Shown above is the architect's drawing of the new laboratory which will form an extension of the Sterling Hall of Medicine (at extreme left with dome) on Cedar Street in New Haven.

A new \$1 million laboratory for anatomy and biochemistry will be constructed at the Yale School of Medicine. Work will start this summer and is expected to be completed by September, 1958.

The four-story building will be constructed on a site now partially used as a parking lot and extend southeast up to the Old Dispensary Building shown at the extreme right of the drawing.

The U. S. Public Health Service has contributed \$482,000 to the building cost under its Health Research Facilities Construction Program, and the University is providing matching funds to cover the remainder of the cost. Included in Yale's share

is a gift, announced last year, of \$200,000 from the Longwood Foundation of Philadelphia.

The new building will provide long needed laboratories for the anatomy and biochemistry departments, now concentrated in the Sterling Hall of Medicine. When the new building is completed these two departments will be able to conduct their teaching and research programs both in the existing laboratories as well as in the new building. Both the faculty and students working in these two departments at the medical school have doubled in size since the existing facilities were constructed some 30 years ago.

What Happened in Hartford

The 1957 General Assembly adjourned on time and quietly. Its record was not very exciting and it was so concerned with fiscal affairs that it perhaps slighted some matters that were deserving of attention. It did a few good things in Health and Welfare enactments that will be remembered, and passed measures in which the Society had long been interested.

Authorized the Tuberculosis Commission to allocate State subsidies to district health departments and some private agencies.

Appropriated \$74,475 for improvements at the partially State maintained but privately owned American School for the Deaf.

Created a seven-member State Board of Mental Health; empowered it to establish administrative policies for five State mental institutions and to appoint superintendents of those institutions, and drastically reduced the powers and authority of the institutions' Boards of Trustees.

Transferred administration of Undercliff Hospital at Meriden, to the Board of Mental Health.

Made the State Board of Education responsible for maintaining a vocational rehabilitation unit and for disbursing Federal and other funds provided for the work.

Strengthened regulations on maintenance of cattle herds free from brucellosis.

Directed the Legislative Council to study need for legislation dealing with dangers of atomic radiation exposure of industrial workers.

Authorized municipalities to enter into contractual agreements for the provision of health services upon approval of the State Health Department.

Appropriated \$425,000 to the State Health Department for purchase and distribution of antipolio vaccine for free inoculation of persons under 20 years of age, regardless of their ability to pay.

Provided the regulatory and registration power of the State Health Department over all sources of ionizing radiation.

Required labeling of household preparations containing hazardous substances as such and provided criminal and other penalties for violations. (Proposed and supported by State Medical Society.)

Made it illegal to manufacture, possess, control, sell, prescribe, administer, dispense or compound

dangerous or habit forming drugs except as authorized under statutory restrictions.

Strengthened restrictions on the refilling of prescriptions for dangerous and habit forming drugs.

Authorized the use of blood grouping tests in paternity cases.

Eliminated priorities on the use of antipolio vaccine; set up machinery for regulating the distribution of any biological product in the event of an epidemic.

Authorized two or more municipalities to enter into contracts for health services.

Restricted, with some exceptions, the use of the title "psychologists," to persons certified by the board of examiners.

Eliminated the requirement that applicants for nursing licenses must be citizens or have declared their citizenship intentions.

Tightened the nursing law by stipulating that domestic employees can care for ill persons only as an incidental part of their jobs, and are not "initially employed in a nursing capacity." (Advocated by the State Medical Society.)

Appropriated \$200,000 for a "study and treatment" center for certain mental illnesses, including sexual deviation.

Established machinery for integration of State employees' pension system with Federal Social Security; authorized a \$1,050,000 appropriation and up to \$3 million in short term borrowing to pay the State's share retroactive from January 1, 1956 and through 1960.

Required that all adoptions be made through State Welfare Department or licensed agency to guard against black or grey market adoptions. (Advocated by State Medical Society.)

Provided that private hospital rates charged for care of State old age pensioners be determined annually by a committee of State department heads. Present allowance is \$5 per day per patient.

Allowed transfer of mental private hospital or tuberculosis patients to public hospitals to qualify the State for matching Federal funds.

Consolidated the State tuberculosis commission and the commission on chronically ill, aged or infirm into a new seven member Commission on Tuberculosis and Other Illnesses.

Limited public nurse agency charges for visits to State welfare patients to the same rate as that charged the general public.

Limited State aid to welfare patients to amounts set forth in medical fees schedules set up by the State Commissioner of Finance and Control.

Redefined mentally ill person as "person afflicted by mental disease to such extent that he requires care and treatment for his own welfare, or the welfare of others; or of the community."

Created a Commission on Services for Elderly Persons.

Established a poison control center in the State Department of Health to help physicians, hospitals and the public to determine the kind of poison that a person may have come in contact with or have accidentally swallowed. (Advocated by the State Medical Society.)

Blue Shield Award to CMS

Connecticut Medical Service, Inc. has just received, for the 5th consecutive year, a certificate from the National Association of Blue Shield Plans in recognition of compliance with the membership standards as established by the Commission of Blue Shield Medical Care Plans for nonprofit medical care plan organizations.

The Certificate is issued from Chicago, the national headquarters for the 72 Blue Shield plans in existence throughout the United States, Canada, Hawaii, Puerto Rico, Newfoundland and Nova Scotia. The award reads "in recognition of services directed toward meeting adequately the health needs of the public, maintaining the high quality of medical care rendered by the medical profession, and the active support of the participating physicians, (there are 2,821 such physicians in the State of Connecticut who participate in CMS) this certificate is granted by the authority of the Commission of Blue Shield Medical Care Plans."

Today one million Connecticut people, (over 45 per cent of the total state population) have CMS coverage for the prepayment of physicians' services. And 2,821 surgeons, specialists and general practitioners are CMS participating physicians who guarantee service benefits, the unique full payment provision of the CMS contracts.

Connecticut Regional Blood Program

In a recent article in the *New England Journal of Medicine* (June 20, 1957), Dr. Hugh Fudenberg and Dr. Fred H. Allen quote two cases of hemolytic transfusion reactions occurring after the ad-

ministration of donor bloods even when these bloods had apparently been shown compatible by cross-match tests. It was possible to determine in both cases that there was no laboratory error.

It was stated some years ago that in eighty per cent of all transfusions some immunization occurs. This immunization can produce an anamnestic response if the patient is subsequently transfused. This danger is not theoretical but real, and, with the increased use of blood for all purposes in Connecticut, can be expected to occur more frequently in our hospitals in the future.

Blood can be a fatal as well as a life-giving fluid.

	JULY 1, 1956 THROUGH JUNE 30,	
DONORS	JUNE 1957	1957
Donors accepted	7,444	89,928
Donors rejected	816	9,512
Donors registered	8,260	99,440
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from Center	6,576	75,776
Blood collected by hospitals.....	539	8,103
To fractionation stock pile.....	324	1,800
To out of state hospitals.....	145	1,239
	7,584	86,918
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	108	1,130
Processed into packed cells.....	0	66
Processed into liquid plasma.....	918	9,960
	1,026	11,156
Discarded—unfit and broken.....	42	654
Grand Total—distribution of blood....	8,652	98,728
Blood returned to Center for processing into plasma and fractions.....	906	9,052
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	37	606
Fresh frozen plasma (125 cc.).....	119	2,166
Serum albumin (100 cc.).....	84	1,804
Immune serum globulin (2 cc.).....	0	3
Packed red cells (bottles).....	0	66
Fibrinogen (bottles)	0	16

Connecticut Advisory Committee on Foods and Drugs Meeting of May 23, 1957

The member societies, institutions and agencies were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut Veterinary Medical Association, Dr. Joseph

DeVita; Food and Drug Commission, Mr. Herbert Plank; Pharmacy Commission, Dr. Felix Blanc; State Department of Health, Dr. James Hart; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut College of Pharmacy, Dean H. G. Hewitt; Representative J. McCullough Turner of Bethany was also present.

THE HAZARDOUS SUBSTANCES BILL

The chairman asked Dr. Turner to give the final report on this bill, because it was he more than any other member of the General Assembly who had worked for its passage from the beginning.

Dr. Turner reported that Representative Nancy Draper had read the bill in its final form (as drafted by Mr. Waterhouse and approved by the Committee on Public Health and Safety) to the House, which had passed it without opposition; it had then been passed by the Senate and approved by the Governor on May 15. The new law, known as Public Act No. 271 (a resume of which will appear in a subsequent issue of the JOURNAL), would take effect on January 1, 1958. The day following its signing by the Governor (that is, on May 16) he (Turner) had introduced House Joint Resolution No. 179, as a memorial to the late Dr. William T. Salter.

At the conclusion of Turner's speech in favor of this resolution, Mrs. Prokop of Stratford also recommended its passage. The resolution was passed by voice vote of the House without opposition; later that same day it was passed by the Senate upon motion of Senator Minetto.

Dr. Turner closed his report by informing the Committee that on April 16 Senator Prescott Bush had introduced in the U. S. Senate Senate Bill No. 1900, which was intended to accomplish on a national scale what Public Act No. 271 did for Connecticut. He said that our Committee should be proud that we were responsible not only for Connecticut's having a hazardous substances labelling law but for furnishing to Senator Bush both the idea and the language for a similar Federal law.

The law as finally passed by the General Assembly differs from House Bill 1061 chiefly in that soap, soap products and "sensitizers" are excluded from its jurisdiction.

Dr. Blanc praised Dr. Turner for his "outstanding job" in handling the progress of the bill through the legislature. In reply, Dr. Turner thanked Dr. Blanc for what he had said, but remarked that it should not be overlooked that Mr. Norman Parsells had worked hard for the bill.

On motion of Hewitt, seconded by Wedberg, it was voted that an engrossed resolution of thanks for his help in securing the passage of the law be presented to Dr. Turner.

THE POISON CONTROL CENTER BILL

Dr. Fisher remarked that he understood that this bill (which the Committee had not actually sponsored but which was intended to accomplish objectives the Committee had long favored) had received a favorable report from the Committee on Public Health and Safety, but had been referred to the Appropriations Committee because it carried an appropriation of \$38,200 to defray the expenses of administering it for two years. He had been informed that certain insurance companies in Hartford favored this bill to such an extent that they were prepared to back the formation of poison control centers with additional private funds if necessary.

Dr. Hart stated that some 40 cities in the country already had poison control centers, and the U. S. Public Health Service was proposing to establish a national center to coordinate exchange of information between state and local centers.

THE VETERINARY MEDICAL PRACTICE ACT

Dr. DeVita reported that the bill drawn up by his association to regulate the practice of veterinary medicine had been passed by the General Assembly as Public Act No. 360. He said that this was a very comprehensive law which included wording that gave the veterinary medical profession a code of ethics to practice under.

THE "ORAL NARCOTIC BILL"

Dr. Blanc remarked that the present legislature had also passed a law to permit physicians to prescribe drugs containing narcotics by telephone.

CORONEED

At the meeting of July 26, 1956 the question of whether the labelling and advertising of Coroneed, a preparation sold "To Help the Heart," was false, misleading or otherwise nonpermissible, had been referred to a subcommittee composed of Drs. Dwyer, Geiger and Marvin. At the present meeting Mr. Plank reported that Coroneed was no longer being offered for sale in Connecticut, but had been replaced by a similar product called Super-Coronaaid; he showed the Committee samples of the Super-Coronaaid advertising.

It was agreed to refer this material to Drs. Dwyer and Geiger.

REGIMEN AND P. P. A. DIET TABLETS

Mr. Plank displayed advertising for both of the above products which had appeared in local newspapers. Dr. Fisher had also brought a page from the *New Haven Register* of May 20, 1957, which carried a large advertisement for Reginien-Tablets headed: "Amazing New Medical Release! (Available Now Without Doctor's Prescription) No-Diet Reducing with New Wonder Drug for Fat People." At Mr. Plank's request, the advertising for both products was referred to a subcommittee composed of Dr. Hart (chairman), Dr. Giarmen and Dr. Fisher.

PSOREX SYSTEM

Mr. Plank showed the members an advertisement in the *New Haven Register* of March 31, 1957 of a Psorex System, consisting of two 4 oz. jars of ointment, retailing for \$7.50, which was claimed to give relief to psoriasis sufferers.

It was agreed that this advertisement would be referred to Dr. Jack J. Albom with a request that he report at the next meeting on whether it was false or misleading.

RIT EASTER EGG COLORING TABLETS

Mr. Plank reported that recently a child in West Haven had become very ill as a result of swallowing some of these dye tablets whose labelling indicated only that they contained "certified pure food colors;" the child had been rushed to the hospital for emergency treatment, and had recovered. Plank thought that products of this sort ought to carry warnings to keep them out of the hands of small children, as well as directions for first aid if they should be swallowed.

VETERINARY REMEDIES SOLD BY FEED STORES

Mr. Plank displayed a number of drugs for veterinary use that had been purchased from various feed stores without prescriptions. He said that he believed some of these were not properly labelled with directions for use and other information required by law, and asked for the Committee's opinion on them.

These preparations were turned over to Dr. DeVita to study and report on at the next meeting.

SUPER STRON FORMULA

Dr. Fisher showed the members a circular he had received in the mail which advertised "Super-Stron

Formula tablets designed to help one keep feeling fit after 45;" the supplier was Nature Food Centre of New Haven. No formula was given, but the circular said the capsule contained "an all-purpose compound" that had something "to help prevent lowered general resistance; for the blood; for the nerves; for restlessness and tension; for the heart; for the appetite; for the glands; for the muscles; for the liver; for the kidneys; for the eyes; for general body building; and for digestive disturbances."

No action was taken on this subject.

Connecticut Joint Commission for Improvement of Care of the Patient Meeting of May 16, 1957

Present, Albert W. Snoke, M.D., presiding, CHA; Stuart W. Knox, CHA; Mary E. Brackett, R.N., CLN; Mrs. Frances Richardson, R.N., CLN; Anna E. Ryle, R.N., CSNA; Rosemary O'Neil, R.N., CSNA; Herbert D. Lewis, M.D., CSMS.

Guests: Lillian B. Reilly, R.N., assistant chief examiner, Connecticut Board of Nursing Examiners; Edgar L. Geibel, chairman, CHA Council on Administrative Practice and Administrator, Stamford Hospital.

INTER AGENCY REFERRAL FORM

It was recalled that at the last meeting the Commission had voted to reaffirm the principle that a standard inter-agency referral form is of major importance to best patient care and recommended that the Connecticut League for Nursing arrange for trial in a selected geographical section of the State. The CLN is now preparing to try this form in the Hartford area on approximately 600 cases and has enlisted the active support of Hartford Hospital and the Hartford Visiting Nurse Association to conduct the trial.

The CHA is expected to furnish funds to purchase a trial supply of the forms and has been assisting with the form design.

COSTS OF DIPLOMA PROGRAMS IN NURSING

It was reported that hospitals generally have shown interest in developing the net cost of educating student nurses enrolled in hospital diploma programs. While the Connecticut Hospital Association, through its program in uniform accounting and cost analysis, is able to develop the out-of-pocket expenses involved in maintaining schools of nursing, it is seeking a method for placing a dollar value on the service rendered by students while in training.

In March, 1956, the Connecticut Public Expenditure Council completed a two year survey of post-secondary school education in Connecticut at the request of former governor John D. Lodge. The questions it attempted to answer were: "1. Who should go beyond the secondary school? 2. Who should provide higher education? 3. Who should pay for higher education?" In April, 1956, President Eisenhower appointed a committee on education beyond high school, with a broad mandate to alert the American people to the critical problem in post high school education. The study is being implemented locally by the Connecticut Council on Higher Education under the Chief, Bureau of Higher and Adult Education, Connecticut State Department of Education. Generally, all post secondary schools are concerned about the blooming birth rate going and following World War II, which is expected to double the candidates for post secondary education within the next fifteen years. The crest of this crop of "war babies" has now reached the junior high schools and within a very few years will be ready for higher education.

If schools of nursing are to avail themselves of this supply of man power, they must project the resources which will be needed and anticipate the sources of funds to pay for them. Currently, much of the net cost of nursing education in hospital diploma programs is being absorbed by the sick patient. While this is essential at the present time, hospitals are committed to finding ways to relieve this burden from the sick patient and put it upon the community served.

(Recorders Note: Through the efforts of the American Hospital Association, Washington legislators have recognized hospitals for the first time as institutions of higher learning as the Banking and Currency Committee has appropriated \$25 million for housing loan assistance to intern and nurse training hospitals along with colleges.)

On a motion made and duly seconded, it was

Voted to ask each parent organization to appoint two representatives to a subcommittee of the Commission for the purpose of developing the costs of nursing education in Connecticut hospital diploma programs. The subcommittee will elect its own chairman and secretary and report its finding to the Commission on conclusion of its work.

NURSES FOR A GROWING STATE

Reference was made to a report just released by the National League for Nursing which predicts

that nursing schools face an unprecedented expansion during the next fifteen years if the ratio of nurses to population is to be maintained and especially so if more students are to be prepared to meet the heavy demands for nursing service.

The National League for Nursing research staff has developed a method with which to predict future personnel and educational needs in nursing during the course of this study, and has urged state planning groups, such as this Commission, to apply the study to their own areas with help of the National League for Nursing.

On a motion made and duly seconded, it was

Voted to have the same subcommittee mentioned in above work with the research staff of the National League for Nursing in projecting future needs for nursing service in the State of Connecticut.

A Conceptual Clinic for New Instrumentation for Medicine and Biology

Almost 125 scientists and engineers from 60 different universities and industrial institutions gathered at the New England Institute for Medical Research in Ridgefield, Connecticut, for a two-day symposium on June 10 and 11. The symposium was entitled "A Conceptual Clinic for New Instrumentation for Biology and Medicine" and was designed to present to physical scientists and engineers some basic biomedical problems for which there is no instrumentation or for which the existing instrumentation is inadequate. The relative difficulty of communication between the biomedical and the physico-engineering fields has resulted in considerable gaps which can be filled. This two-day symposium was an attempt to help remedy the deficiency in communication. Virtually all of the biomedical problems which were presented were presented in physical and engineering terms.

Among the speakers were Drs. Daniel Boroff, Christopher Coates, Richard Day, John Fitzgerald, Lewis Fox, Irving Friedman, Harold Genvert, John Heller, J. Miles O'Brien, Norbert Wiener, and Richard Zucker. The problems presented were far-ranging. An attempt was made to present three aspects of problems in instrumentation: (1) instruments to be used by the practitioner, (2) instruments to be used in the analytical laboratory, and (3) instruments for use in the research laboratory.

Dr. Norbert Wiener discussed the instrumentation currently in use by himself as well as that

proposed for further use in order to analyze fine structure in alpha rhythm from electroencephalograms. Dr. Wiener indicated that the astonishing regularity of the periodicity of peaks in the fine structure could be a useful tool for further physiologic investigation of brain mechanisms and drugs.

Dr. Richard Day explored the physical parameters in a developing and mature subdural hematoma and discussed instrumentation for precise localization. He also discussed the probable correlation between illness in premature infants and the rate of fingernail growth. He suggested the need for instrumentation which might enable the measurement of the rate of fingernail growth within a relatively few minutes.

Dr. John Fitzgerald suggested the greater need for molecular knowledge in health and disease. He suggested that a variety of physical principles might be used in order to substitute physical methods for chemical analytical methods in a variety of body fluids. Such techniques could result in a quantum jump in the speed, delicacy, accuracy, and range of possible chemical determinations.

Dr. Lewis Fox requested instrumentation which might accurately measure the degree and direction of the impact of one tooth upon another because of the probable interrelation between malocclusion and periodontal disease.

Dr. Irving Friedman requested a method which might obviate the use of x-ray in the determination of pelvimetry so as to spare both fetus and ovaries of the pregnant woman from as much radiation as possible.

Dr. Harold Genvert explored some of the areas in surgery where instrumentation over a half century old might be replaced with more modern and effective instrumentation.

Dr. John Heller explored a variety of physical parameters which might be used in developing instruments to measure various determinants in physical diagnosis, including differential density, swelling, tumors, cavitation, and cyst formation.

Dr. J. Miles O'Brien suggested the design of a device which could effectively induce transient force fields in nonmagnetic foreign bodies in the eye so that they could be removed in a manner similar to the magnetic removal of ferrous foreign bodies. He also explored the use of a moderate voltage, high amperage linear accelerator for ophthalmic tumors.

Christopher Coates demonstrated some of the

bioelectric parameters manifested by electric eels, including their ability of underwater localization of foreign bodies and electrical discharges by what appears to be electrical means.

The two-day session culminated with a variety of suggestions as how to increase the interchange of physical and engineering knowledge with individuals in the biomedical field so as to better capitalize upon this knowledge for new instrumentation.

Blasko Resigns

John J. Blasko, M.D., Connecticut's first Commissioner of Mental Health, has resigned his post to rejoin the Veterans Administration in Washington, D.C. Dr. Blasko, who came to Connecticut in May, 1954, expects to leave the State during August, 1957. He is a Diplomate in the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association, and a Fellow of the American Medical Association. At the time of his Connecticut appointment, he had served for several years as national director of the VA Psychiatric Training Program.

Elias J. Marsh, M.D., chief, Division of Community Services, is expected to serve as acting head of the Department until a new Commissioner is obtained. According to legislation just passed at the current session of the General Assembly, the new Commissioner "shall be a doctor of medicine, licensed to practice medicine in Connecticut and shall have a broad experience in hospital administration and, if practicable, in psychiatry."

Blumenthal and Donnelly to Board of Mental Health

Governor Ribicoff has appointed Andre Blumenthal, Norwalk, and William J. Donnelly, Greenwich, to membership on the new seven-member State Board of Mental Health, which is to assume policy control of the State's mental hospitals. Both Mr. Blumenthal, who is a trustee of Norwalk Hospital and currently a member of CHA's Governing Board, and Mr. Donnelly, who is administrator of Greenwich Hospital, are past-presidents of the Connecticut Hospital Association. In addition, both are serving as members on the Advisory Committee of CHA's Project for Improved Personnel and Dietary Administration.

Other appointees are: Dr. Rosemary Park, president, Connecticut College, New London; Dr. John Donnelly, clinical director, Institute of Living, Hartford; C. Elias Clark, Woodbridge, Yale law professor; Dr. F. C. Redlich, professor of psychiatry, Yale School of Medicine; and Dr. Franklin S. DuBois, psychiatrist, New Canaan.

Dr. Emily Barringer Elected Honorary Member

Dr. Emily Dunning Barringer of Talmadge Hill, Connecticut, now 80 years old, was elected an honorary member of the Connecticut State Medical Society at its 165th Annual Meeting on April 30. Dr. Barringer, widow of the well known urologist and a graduate of Cornell Medical School, became famous as the first woman intern to ride a hospital ambulance. This was in New York City in 1903.

For many years Dr. Barringer was a member of the House of Delegates of the American Medical Association and the only one of her sex in that august body. Now living in Connecticut, she is still claimed by the Medical Society of the State of New York as one of its most illustrious members.

Replying to the telegram from Dr. Barker announcing her election she sent this message:

"I feel deeply honored and appreciate most heartily the recognition you all have given me. The fact that I feel sure that some of my old friends, colleagues whom I have worked with through the years, are largely responsible for this honor has added much to the zest of the occasion for me.

"I send my heartfelt thanks to you and the other members of the Connecticut State Medical Society."

Connecticut Radiologists Elect Officers

At the annual business meeting of the Section of Radiology of the Connecticut Medical Society,

which was held at the Hartford Golf Club on June 27, 1957, the following officers were elected: President, Frederick J. Fagan of New London; President-Elect, Robert Shapiro of New Haven; Executive Board—3 years, John Burbank of Meriden; Executive Board—2 years, William Dobbs of Torrington; Executive Board—1 year, Edward J. Sennett of Hartford; Secretary-Treasurer, Ralph J. Littwin of Bristol.

Fairfield County

"You and Your Medical Care" is the title of the display to be exhibited at Danbury Fair September 28 to October 6, the Public Relations Committee of the Fairfield County Medical Association makes known. This will mark the fourth successive year in which the Association has held booth space at the Danbury event. Physicians and members of the Woman's Auxiliary are being recruited to staff the exhibit.

Another in a series of indoctrination meetings for new members is being planned by the Fairfield County Medical Association for September 25. The semi-annual session, at which time new members will be elected, will be held October 3.

A revised brochure covering the Fairfield County Medical Association's Retirement Plan is being mailed to members. Outlined for the first time is a life insurance program in which physician investors may, at their option, secure up to \$30,000 in coverage without a physical examination. The investment, a mutual fund, is now known as Fiduciary Mutual Investing Company, Inc. More than 100 members have entered the program so far.

Beginning July, members of the Woman's Auxiliary to the Fairfield County Medical Association became subscribers to *News Capsule*, the Association's monthly bulletin. In the same month also

CONNECTICUT CLINICAL CONGRESS

HOTEL STATLER — HARTFORD

DECEMBER 11 and 12

Save the date

hospital interns were placed on the publication's mailing list.

Hartford County

At its recent meeting the Board of Directors of HCMA voted to inform the entire membership through the medium of the Bulletin of an action of CMS concerning claims submitted by Connecticut physicians for services rendered members of their immediate family—specifically a wife or children—by themselves.

New president of the Connecticut Heart Association is Dr. William J. Lahey, director of medical education at St. Francis Hospital.

Speaker at the sixth Spring Institute on Youth and Child Development, sponsored by the National Conference of Christians and Jews was Dr. John Donnelly. Dr. Donnelly spoke on the elimination of prejudices.

New president of the Hartford County Chapter of the Connecticut Academy of General Practitioners is Joseph Massaro of Manchester. Vice president is Isadore Friedberg of Newington. Secretary of the chapter is Leo P. Giardi and Treasurer, Orlando Orfitelli.

Conducting a series of lectures by the Board of Life Insurance Medicine was D. Sergeant Pepper. Dr. Pepper is associate medical director of the Connecticut Mutual and chairman of the Board of Life Insurance Medicine. The program was designed to acquaint doctors entering the insurance field with the basic fundamentals of the life insurance business. Serving on the faculty were: J. Grant Irving, Kenneth F. Brandon, Archibald C. Wilson and Henry B. Rollins.

John C. White of New Britain, former president of the Connecticut Heart Association, received the Association's "Distinguished Service Award." The Association cited Dr. White for his "encouragement of expansion of community service and educational programs" on local levels during his term of office as president.

Elected president of the Women's Auxiliary of the Manchester Memorial Hospital recently was Mrs. Charles Jacobson, Jr. First vice president was Mrs. Alfred Sundquist.

New psychiatrists for the rehabilitation program of the Connecticut State Prison are Robert C. Doherty, Richard H. Maloney and Charles F. Von Salzen. Their work will be under the joint super-

vision of Thomas C. Carey, and George A. Crawley, chief medical officer.

Ernest Shortliffe, assistant medical director of the Hartford Hospital, has been elected to a three year term on the Board of Directors of the National League of Nursing.

Philip Partington, recently appointed assistant medical director of the Hartford Hospital, has been elected to the Executive Committee of the Board of Directors of the Greater Hartford Community Council.

Alfred L. Burgdorf, Hartford health officer, addressed the recent New England Conference on Aging held at Amherst, Massachusetts on "Health, A Home Care Problem." More than 300 persons attended this, the first conference of its kind in New England, sponsored by 40 New England organizations.

John Donnelly has been named medical director of the Institute of Living in Hartford. Just recently Dr. Donnelly was also elected president of the Connecticut District Branch of the American Psychiatric Association, was appointed chairman of the Committee on Mental Health of the State Medical Society, and was appointed by Governor Ribicoff as a member of the State's new seven member Mental Health Board.

Anthony W. Branon, formerly a surgeon practicing in Hartford, died at his home in Old Saybrook on July 3 at the age of 69 years.

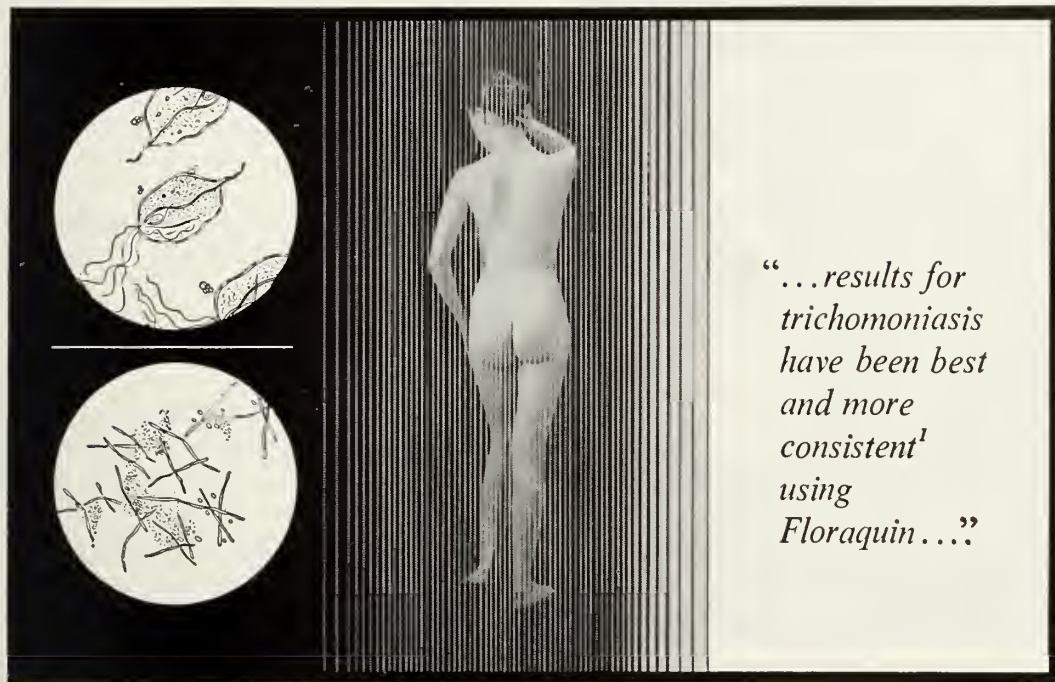
Hartford has a new deputy director of health, Homer C. Wick, formerly a member of the Nassau County (N. Y.) Department of Health. He has been associated recently with the Life Extension Examiners.

Peter J. Scafarello, secretary of the Connecticut Chapter of the American Academy of General Practice, has been appointed to the National Insurance Committee of the American Academy of General Practice.

The A.A.G.P. has a membership of 24,000 physicians throughout the United States and has one of the most comprehensive insurance programs of any medical organization. The insurance program includes such policies as health and accident, catastrophic, overhead insurance and malpractice. The committee is now considering writing a form of life insurance for its members.

It is the duty of this committee to consider writing any form of insurance in order to protect

EFFECTIVE, DEPENDABLE THERAPY FOR VAGINITIS



Floraquin[®] eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported² trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

Floraquin effectively eradicates both trichomonal and monilial vaginal infections through the action of its Diodoquin[®] content. Floraquin also furnishes boric acid and sugar to restore the normal vaginal acidity which inhibits patho-

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1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama 25:182 (Feb.) 1956.

2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. 16:570 (Dec.) 1955.

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WEST HARTFORD BOY RECEIVES AMA CITATION



Robert N. Nathanson, 16, a junior at William Hall High School in West Hartford, accepts his American Medical Association Honorable Mention citation and the congratulations of Dwight H. Murray, M.D., AMA president, for his exhibit on the "Fungistatic Action of Squalene and Certain Unsaturated Fatty Acids of the Skin on *T. rubrum* in Vitro" displayed at the National Science Fair in Los Angeles, May 9-11.

The exhibit was one of four at the Fair selected by a special AMA judging committee as being among the best in the basic medical sciences, and the presentations were made at a banquet in the Biltmore Hotel given for the 600 Fair participants by the American Medical Association.

Bob also won the AMA's honorable mention citation at the 1956 National Science Fair in Oklahoma City for his exhibit on "The Effect of Aureomycin on the Encystment and Excystment of the Amoeba." He again won his trip to the Los Angeles fair by winning in the regional Eighth Connecticut Science Fair in Hartford earlier this spring.

The National Science Fair, in which the AMA has participated for the second consecutive year, is

sponsored by Science Clubs of America to encourage talented students in the study of science as a career.

PHYSICIAN AWARDED OSLER MEDAL

Sebastian R. Italia of Hartford has been awarded the William Osler Medal by the American Association of the History of Medicine for the best medical essay on the history of medicine in national competition. The subject of his essay is "Elisha North: Experimentalist, Epidemiologist. Physician (1771-1843)." Dr. Italia graduated from Yale University School of Medicine and is now serving an internship at Hartford Hospital.

Middlesex County

The partnership for the practice of orthopedics of Alfred N. Sweet and James Glessner has been dissolved. Richard Sweet has joined his father in practice. James Glessner has open his own office at 195 South Main Street, Middletown.

Harold Conn resigned as director of medical education at Middlesex Memorial Hospital. The new director is Patrick J. Mulrow.

John Kelly and Margaret Kelly have moved their offices to 100 Broad Street, Middletown.

Three new interns have come on duty at the Middlesex Hospital. They are Cornelius Boelhouwer, a graduate of the Medical School of the University of Leyden, the Netherlands; Nathaniel Bronson, a graduate of Johns Hopkins University Medical School, Baltimore; and Samuel Cornett, a graduate of Queens University Medical School, Belfast, North Ireland.

Herbert Magram is a newcomer to Middletown. He has opened an office for the practice of obstetrics and gynecology at 100 Broad Street.

William Irving, who has been a pediatrician in Old Saybrook, has closed his office. He has taken a full time appointment in the Pediatrics Department of the Yale Medical School and is going to work on the problems of retarded children.

New Haven County

H. M. Marvin, past president of the American Heart Association and literary editor of the *JOURNAL* was the principal speaker at the annual meeting of the New Haven Heart Association on June 28.

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NEW BOOKS IN REVIEW

EPILEPSY, GRAND MAL, PETIT MAL CONVULSIONS. By Letitia Fairfield, C.B.E., M.D., D.P.H. New York: Philosophical Library, Inc. 1957. 159 pp. \$4.75.

Reviewed by JOHN DONNELLY

Common sense and appreciation of reality factors make this handbook a very useful text for both professional and lay persons in dealing with epileptic patients. Throughout the book one is aware of the great sympathy and understanding of the author for the patient and for those who come in contact with this problem. It is not a technical book for neurologists, rather is its greatest strength in the straight-forward but sympathetic treatment of the many psychological concomitants of these conditions. The emphasis is on the management of the child and the adult at home, at school, and at work. Interesting is the discussion of the placement of adult epileptics in industrial work. It is a plea for the more rational approach to the epileptic problem on the community level.

This is a book written essentially for intelligent persons living in the British Isles since a portion of the book deals with the facilities which are available in Great Britain. Aside from these particular aspects, this handbook can be well recommended to those interested in the psychological management of the epileptic.

BATTLE FOR THE MIND. By William Sargant, M.D. New York: Doubleday & Company, Inc. 1957. 263 pp. \$4.50.

Reviewed by JOHN DONNELLY

Hell and damnation, rock 'n roll, revivalism and voodooism, religious and political conversion, brain washing in religion and politics, drugs and psychoanalysis, shock therapy and heresy are included in the subject matter of this very readable study. It is the purpose of the author to reduce to physiological terms all the methods whereby the mental stability of the individual may be decreased and his various convictions can be changed by persuasion, mild, moderate, or intense. Dr. Sargant traces from Hippocrates the four types of temperament described in various ways through the ages. He correlates these with four temperaments of dogs postulated by Pavlov. He discusses the three phases of transmarginal inhibition—the so-called equivalent, paradoxical, and ultraparadoxical phases of the Russian scientist—with the reactions which occur in human beings under stress. He points out that human beings, as do dogs, react ultimately in similar fashion, though there are variations according to the type of temperament. The point is also made that, for example, in drug treatment of emotional disorders, the therapeutic dosage varies according to the temperament and that unless the dosage is in keeping with the temperament, adverse effects may be obtained.

Dr. Sargant's interest in Pavlovian physiology developed

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as the result of his experiences during the Second World War with acute psychiatric reactions developing in Allied soldiers under fire. He found that whereas sedatives were effective in many cases, in some they appeared to worsen the psychic reactions. Thus, study showed that in the "strong, excitatory," or choleric type of temperament five to eight times the usual dose of sedative was necessary for the desired result.

The author's thesis is that all held opinions are the result of the experiences of the individual who is conditioned by these experiences in the Pavlovian sense. Stress within a certain limit, characteristic of the given individual, can be dealt with satisfactorily but beyond that limit may give rise to one of the three types of transmarginal inhibition. He correlates these states with various clinical syndromes. He holds, with most psychiatrists of all schools, that any person if exposed to stress, characteristically intolerable to that individual, will develop psychic disturbances but he believes these can be explained as physiological reactions.

The author proceeds to examine the emotional factors and the behavioral responses in the wide variety of conditions mentioned earlier. Persuasion may be intensified or rendered easier by physical debilitation as well as by emotional exhaustion. Use of this is made in brain washing, especially by deprivation of sleep. Repetition ad infinitum

of a question likewise may be utilized to stress the human subject.

The techniques employed by John Wesley are compared to those in modern political systems and numerous are the quotations from the revivalists and their disciples to prove the author's points: for example, that intense emotions must be roused—fear, anger, or resentment—but at the critical moment an escape must also be presented, to be seized as the only means of survival.

Dr. Sargant also offers some interesting suggestions as to how one may avoid being brain washed. One must not try to fight the foe—to apparently yield is better; cynicism and a sense of humor were mind savers. Among the most susceptible are those determined to resist the process. The only problem about these recommendations is that those who already possess these attributes are unlikely to have emotionally charged opinions while those who do not have these attributes perhaps need to be "brain washed" to develop them.

This book will be strong meat for many. It will itself arouse many emotional reactions in readers whose beliefs may be threatened. Nevertheless, though the author does not perhaps prove this thesis, he does point up basic factors common to many, if not all, schools of psychiatry and he moves in the direction of unification of diverse theories.



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BONE STRUCTURE AND METABOLISM. A Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Cecilia M. O'Connor. Published jointly by J. & A. Churchill, Ltd., London, and Little, Brown & Co., Boston. 1956. 299 pp. \$8.

Reviewed by JULIAN KAISER

This book contains the edited transcriptions of twenty-one papers which were delivered by participants in the Symposium on Bone Structure and Metabolism held in London, 12th to 14th July, 1955, under the auspices of the Ciba Foundation. Dr. C. E. Dent of the University College Hospital Medical School, London, acted as chairman of this comprehensive group of twenty-eight investigators who met to share their interests and studies in this field.

The papers cover many aspects of the structure and metabolism of bone. The first ones concern the more fundamental problems and are followed by others on the related biochemistry and physiology. The remainder, about half, present a number of clinical considerations. At the conclusion of each paper there appears the comments of various members of the symposium which are presented as they naturally developed in the discussion.

In several of the first papers concerning bone structure there are differences of opinions which are not fully explained to the satisfaction of a reader who is not versed in basic science. The discussions do not render any of these differences more intelligible to the casual medical reader, but, of course, they were not intended to do so. One presentation of particular interest was that on the nutrition of bone which reviews the general physiology and comments on the role of nutrition in structure, repair, and in bone transplants. A subsequent paper concerned the evolutionary nature of bone repair in rats after experimental fracture by a technique involving P₃₂ which demonstrated that bone repair is a general participation of the total bone apparatus rather than a local mechanism.

The clinical articles included those on vitamin D metabolism and its relationship to citric acid, calcium phosphate, and constitutional hypersensitivity; on parathyroid function; on bone vascularity; on experimental bone disease. These last papers will be of chief interest to the clinical reader. The current status of knowledge on homeostatic mechanism is carefully defined, and that which is not known, but presumed, is equally well delineated. A general discussion on the parathyroid hormone concludes this symposium. An author and subject index is included and numerous references are entered in the various "discussion" sections.

THE YEAR-BOOK OF DRUG THERAPY. 1956-1957 Series. Edited by Harry Beckman, M.D. Chicago, Ill.: The Year Book Publishers, Inc. 514 pp. \$6.75.

Reviewed by JULIAN KAISER

This current book on drug therapy contains abstracts of articles received between August, 1955 and August, 1956. Although the purpose of these volumes is to review drugs, both new and old, new applications and techniques, reviews of clinical and laboratory experiences, it is important that the presentation of this information is not organized on a basis of pharmacological classification. The material is ar-

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ranged under a total of thirty-six clinical divisions and subdivisions. A group of broad topics are covered such as Allergic Disorders, Cardiovascular Diseases, Chest Diseases, Gastroenterologic Disorders, and Infectious Diseases. However, there are also specific sections on all major endocrine diseases, on obesity, pain and many other entities.

Wherever applicable, those articles of broad scope appear first, and those that are related within the framework of a major topic are grouped together. For example, observations on prophylaxis with penicillin therapy are followed by articles and case reports on penicillin hypersensitivity, the detection of antibiotics in fluid milk, and other related studies.

The articles chosen for this review have been abstracted to an approximate 300 to 500 words. The abstracts reflect the findings and interpretations implicitly. However, the editorial comments which appear after nearly two thirds of the entries are most informative and interesting, and reflect the editor's opinion. His choice of articles appears to be particularly timely in the section on Neuropsychiatric Disorders where over half are concerned with toxic side-effects of the tranquilizing agents.

The reference for each abstract is found at the bottom of the respective page. There are a moderate number of illustrations including charts, graphs and photographs. A comprehensive subject and author index is included at the end of the book.

YEAR-BOOK OF MEDICINE. 1956-1957 Series. Chicago, Ill.: The Year-Book Publishers, Inc. 744 pp. \$6.75.

Reviewed by JULIAN KAISER

This most recent edition of this Series on medicine is divided into six main sections: Infections, The Chest, The Blood and Blood-Forming Organs, The Heart and Blood Vessels and the Kidney, The Digestive System, and Metabolism. The editors of each are, respectively, Dr. Paul B. Beeson, Dr. Carl Muschenheim, Dr. William B. Castle, Dr. Tinsley R. Harrison, Dr. Franz J. Ingelfinger, and Dr. Philip K. Bondy.

In all of the divisions the literature selected for review has been arranged in such a fashion that those of broad aspect and subject reviews are first presented. For instance, the leading abstract under Infections probes into certain causes of failure in antibiotic therapy. This is followed by papers assessing the relative merits of certain specific antibiotics, and then, under subtopics, by articles which are concerned with clinical problems such as subacute bacterial endocarditis, the new viruses, etc.

A characteristic and important feature is the matter-of-fact and precise editorial comment which appears after a majority of the abstracts. Although a few papers lose some of their comprehensiveness in being reduced to 400 or 600 words, the overall scope of the review carried out by each editor is broad and inclusive.

A great number of significant descriptive charts, graphs, photographs and x-rays are reproduced, both in the basic investigational articles and also in the case reports, autopsy reviews, and pathological studies. As indicated above, there is a considerable variety in the type of paper selected under each of the main six divisions. The reference for each abstract is listed at the bottom of the page and there is a comprehensive subject and author index appended.

NEW ENGLAND HOSPITALS. 1790-1833. By Leonard K. Eaton. Ann Arbor: University of Michigan Press. 1957. 282 pp. \$6.

Reviewed by STANLEY B. WELD

In this book the author offers a brief sketch of the hospitals of the early 1800's as developed in New England, namely the Massachusetts General, the Boston Dispensary, the Chelsea Marine Hospital, the Charlestown Asylum, the Hartford Retreat, the McLean Asylum, the Massachusetts Charitable Eye and Ear Infirmary, the New Haven General Hospital, and the Worcester State Hospital. As he states in the opening sentence of the preface, "this book is the story of the impact of an institution upon a people." He does not confine himself to the hospitals of New England, however, but devotes several pages to the Bloomingdale Asylum in New York, to the New York Hospital, and to the Pennsylvania Hospital.

Connecticut physicians in particular should find this book of great interest because of the prominent place afforded in it to Eli Todd and his part in the establishment of the Hartford Retreat and in improving the care of the insane.

It is a very readable volume with legible type and a handsome binding. It presents an excellent picture of the struggles of the early New England hospitals and portrays the leading physicians of that era who were responsible for the growth of these institutions.

GUIDE TO MEDICAL WRITING. By Henry A. Davidson, M.D., Editor, *Journal of the Medical Society of New Jersey*. New York: The Ronald Press Company. 1957. 338 pp. \$5.

Reviewed by STANLEY B. WELD

If the author of this volume, which is a practical manual for physicians, dentists, nurses and pharmacists, has omitted anything of value it would be difficult for one to discover it. Beginning with a chapter on how to start an article, the author proceeds in an orderly fashion to take up the organization of the article, the title, the opening paragraph, spelling, punctuation, capitalization, followed by all the little details involved in arranging bibliographies, illustrations and footnotes. In addition he offers advice on how to write an editorial, on how to write a book, on how to revise copy and proof read, on how to prepare abstracts, book reviews and reports of meetings, and finally on how to select the appropriate journal for the article at hand.

Of particular value to the writer and the editor will be his table of practices for compounding words, the chapter on "How to Prepare Summaries and Conclusions," the list of drugs with the trade name and generic name of each, and the dosage and temperature conversion tables.

Dr. Davidson has been a medical writer for 27 years during which time he has been an abstract writer for two national specialty publications, an editor of a county medical society publication and later of a state medical society journal, a contributor to other medical publications, and the author of several books. At present he is assistant superintendent of Essex County Hospital in New Jersey.

If every physician who contemplates submitting an article for publication would use this book as a guide the work of the editor would be made very much easier and the standing of the journal enhanced thereby.



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GENERAL UROLOGY. By Donald R. Smith, M.D., Clinical Professor Urology and Chairman of the Department of Urology, University of California School of Medicine, San Francisco; Consulting Urologist, San Francisco Hospital; Consulting Surgeon (Urology), Veterans Hospital, San Francisco; Chief of the Department of Urology, St. Luke's Hospital, San Francisco. *Illustrated by Ralph Sweet, Los Altos, California. Lange Medical Publications. 1957. 328 pp. \$4.50.*

Reviewed by WALTER A. SCHLOSS

This book reminds one of the college outline series, being paper bound and crammed with facts, but practically no discussion of the very fine points or the pros and cons.

It gives an excellent outline of basic urological facts and tells what is indicated for each condition without going into any details as to the actual operative technique itself.

It reminds one of similar basic urological texts such as those by Colby, by Marshall, by Cordonnier, by Campbell, and others.

This book was written chiefly for the medical student and medical practitioner, and as such I believe that it accomplishes its purpose admirably.

It is filled with pertinent, practical, accurate information, and is an economical way to start or add to one's urological library. To anyone who has any contact with urological diagnosis and treatment, it will prove to be a handy reference.



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The CONNECTICUT STATE MEDICAL JOURNAL

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No. 9

THE MEDICAL MANAGEMENT OF MITRAL STENOSIS

FRANK D. GRAY, JR., M.D., *New Haven*

RHEUMATIC mitral stenosis consists of a deformity of the leaflets of the mitral valve leading to narrowing of the orifice. It is associated with a widespread injury reaction in the myocardium, endocardium, pericardium, as well as some injury to the other organs and blood vessels of the body. Thus it bears little similarity to congenital mitral stenosis in which the original lesion is simply an obstruction to blood flow through the valve. Valvular obstruction is but part of the difficulty in rheumatic mitral stenosis, and this must be borne in mind when considering therapy.¹

PHYSIOLOGY OF MITRAL STENOSIS

Physiologically the dysfunction consists in impaired strength of myocardial contraction because of the injury, and at the same time impairment of the conducting mechanism of the heart giving rise to arrhythmias or heart block. The narrowed valve requires a greater expenditure of energy for a normal amount of blood to be moved through the orifice. Initially the energy demand is met by a more rapid heart rate and also an increased strength of left atrial contraction in accord with Starling's Law of the Heart. During this stage there are few symptoms and in most cases the disease probably does not progress further, but if the compensatory mechanism begins to falter, there follows engorgement of the pulmonary vessels and a rise of pressure in the pulmonary circulation. Dyspnea is noted, and acute pulmonary edema may become a recurring problem. Hemoptysis occurs in a small number of cases. However, a high left atrial pressure maintains flow through the narrowed mitral valve and, although the ability to meet the needs of exercise

The Author. *Associate Professor of Medicine and Director, Cardiopulmonary Laboratory, Department of Internal Medicine, Yale University School of Medicine; Associate Physician, Grace-New Haven Community Hospital, and Woodruff Center, New Haven*

SUMMARY

Since mitral stenosis is but part of the pathology in rheumatic heart disease, a concept that involves only a mechanical block at the valve orifice is inadequate. Pulmonary vascular disease and a failing myocardium are as important as the valve lesion itself. Initially, high pressure in the pulmonary capillaries with ensuing dyspnea, hemoptysis, and acute pulmonary edema causes the disabling symptoms, but in some cases, increasing pulmonary artery resistance leads to severe right sided heart failure. Many patients probably live out relatively normal lives even in the presence of significant mitral stenosis, but those who develop cardiac decompensation at a young age generally have a poor prognosis unless careful medical management is available. Decompensation occurring after the fifth decade is more easily managed.

Good medical management involves the reasonable limitation of activity, the early use of digitalis, the judicious administration of mercurial diuretics, and careful regulation of electrolyte balance with especial reference to sodium and chloride ions. The complications are best managed by prevention, but when they do occur, the treatment is the same as when they arise from other causes.

From the Department of Internal Medicine and the Cardiopulmonary Laboratory, Yale University, The Grace-New Haven Community Hospital, and The Woodruff Center. Presented at the Scientific Session sponsored by the 9263rd Air Reserve Squadron, Stamford, Connecticut, Wednesday, October 3, 1956

may be diminished, there is usually sufficient flow to maintain adequate perfusion of vital organs when the patient is at rest or indulging in mild activity. Should active inflammatory disease be present, or unusual strain of some sort occur, the right heart may fail in this stage, but more commonly the slow rise in pulmonary vascular pressure leads to pulmonary artery sclerosis or hypertrophy of the muscular media of the pulmonary arteries before signs of right heart failure are noted. Concomitant with the structural changes in the pulmonary arteries, the pulmonary artery pressure becomes very high, but the left atrial pressure may actually be lower than before the development of vascular changes, and dyspnea, hemoptysis, or pulmonary edema are often less troublesome in this stage. However, now there will be less perfusion of the mitral valve and even at rest the cardiac output falls to a level below that necessary for adequate perfusion of vital organs. In addition, under the strain of the high pulmonary artery pressure, signs of right heart failure are certain to appear. The actual onset of heart failure will be determined to some extent by the degree of myocardial injury.

There appears to be some modification of this sequence of events predicated upon the rate at which the pathological process develops during three distinct age periods. Probably most people who acquire mitral stenosis live out a relatively normal life span, hardly aware of their disease. However, in the young age group, 6 to 18 years, a few patients, following acute rheumatic fever, will rapidly progress to a stage of massive cardiac enlargement and severe congestive heart failure which may be the result of continuing subacute or chronic rheumatic activity. In any case, this group has a bad prognosis no matter what treatment is used. Another group will weather the childhood period quite well, but develop an inexorably progressive congestive heart failure in the fourth or fifth decades. Although the latter group has a life expectancy of about two to five years from the time of partial or complete invalidism,² the poor outlook could be improved by more careful attention to the details of management. A final group of patients may go through the early and midspan of life with little difficulty, but find increasing evidence of congestive failure in the sixth and seventh decades. The prognosis in terms of life expectancy is quite good for the latter group when compared to groups of similar age but without mitral stenosis. These people are likely to die

of other causes, and the chief importance of their disease lies in its associated disability.

GENERAL PRINCIPLES OF TREATMENT

Before discussing specific therapeutic procedures there are some important aims and general principles that should be enumerated. The aim is, of course, to make the patient better. However, a promise of cure is unrealistic since no one has as yet devised a cure for rheumatic heart disease. On the other hand a pessimistic approach is poor psychology. If a patient has congestive heart failure he will probably always have to limit his activity, limit his diet, and take digitalis. As he grows older these limitations will inevitably become more strict. The patient should know this at the outset, but he must also be encouraged to make the most of whatever activity will fall within his limitations.

Until the physician has had an opportunity to observe the patient under treatment for several months prognosis is hazardous, but if the patient maintains a stable, edema-free state on the recommended program, there is justification for assuming that he will continue to do well as long as he follows the program, unless rheumatic activity or some superimposed disease of the circulatory system occurs. As a corollary, whenever a change in the apparent state of compensation develops, the physician should suspect rheumatic activity or new heart disease.

MODIFICATION OF ACTIVITY

The cornerstones of treatment are modification of activity and digitalis. Modification of activity may consist only in teaching the patient to perform his tasks with efficiency, or, if the cardiac impairment is severe, limiting his activity to functions involving no physical exertion whatever. One should avoid over-limitation, and probably if an error is to be made, it should be on the side of mild overactivity. When dealing with a reasonably intelligent patient one can generally accomplish a great deal by limiting activity. Many of the patient's daily tasks that require considerable exertion may still be carried on if an attempt is made to improve his efficiency. The technical details of this type of job simplification are often rather complicated and time consuming. However, some communities now have work simplification teaching units available for training patients at the physician's request.*

*Connecticut Heart Association, Inc.

The physician should remember that one of the patient's greatest continuing efforts is moving his own body mass, hence a reducing diet is essential for the obese patient. As a general rule of thumb, the patient may be told to engage in any activity that does not produce immediate breathlessness, or undue fatigue at the day's end. Of course during periods of severe decompensation complete bed rest is indicated.

Once clinical evidence of congestive heart failure is present, the need for digitalis is clear. Probably the heart fails before clinical signs become evident. In a study of the circulatory effects of lanatoside C in patients with mitral stenosis, physiological evidence of improved cardiac function has been observed even in those patients who had no clinical evidence of congestive heart failure before the drug was administered.³ This does not mean that we should administer digitalis to all people who have signs of mitral stenosis, rather that we should watch sharply for evidence of diminishing cardiac reserve such as an undue rise in heart rate, exertional dyspnea, paroxysmal nocturnal dyspnea, or ankle edema, and use digitalis as soon as these signs appear.

USE OF DIGITALIS

The choice of digitalis glycoside is immaterial. In general, slower acting drugs have been preferred for the ordinary case. With them the fluctuating digitalis levels of rapidly excreted drugs can be avoided. Digoxin (the name was recently changed to Lanoxin to avoid confusion with digitoxin) appears to have the advantage of rapid action plus reasonable steadiness. Lanatoside C or Ouabain may also be used for rapid action. The need for a rapidly acting preparation must, however, be very rare indeed. On the other hand, toxicity may become a problem and some evidence has been forthcoming to indicate that gitalin offers the advantage of a low therapeutic to toxic dose ratio.⁴

One of the most common reasons for apparent digitalis failure is that the patient has not been given sufficient information about the drug. The fact that he will need it for the remainder of his life, and the danger of attempting to alter the dose to suit what he feels to be his need must be emphasized at the outset. Once an adequate maintenance dose is established it is likely to remain unchanged throughout the patient's lifetime unless active rheumatic carditis or some intercurrent infection develops, hence an apparent change in the patient's digitalis

requirement should signal the need for careful examination. Sometimes an electrolyte imbalance with potassium depletion will lead to signs of digitalis toxicity, or diminished digitalis effect.

MERCURIAL DIURETICS

Mercurial diuretics probably rank next to modification of activity and digitalis in the therapy of the heart failure associated with mitral stenosis. The frequency of administration of mercurial preparations should be determined by the diuretic response. These drugs can be given as frequently as desirable while still obtaining an optimal response, but no oftener; in cases of mild failure, they should be administered only at long intervals. Oliguria, chloride depletion, hyperpotassemia and advanced renal disease are contraindications. Since chloride is excreted in a mercurial diuresis, the drug should be given only after the administration of ammonium chloride for two or three days. In cases of refractory edema, the effect can be potentiated by inducing a hyperchloremic state with Diamox and ammonium chloride followed by a mercurial⁵ or by administering intravenous aminophyllin concomitantly with the mercurial.

DIET CONTROL

Another important measure, diet control, has two aims, first to reduce weight in the case of the obese patient, and secondly to reduce the intake of sodium. Congestive heart failure lowers the renal excretion of sodium ion thus decreasing the amount of salt that can be ingested. In the severely edematous patient, sharp restriction of salt to 500 or even 200 mgm. daily should be attempted. Even with the mildly edematous patient an attempt should be made to reduce salt intake, but in this case the restriction can be a progressive one to allow his taste to adapt itself to a blander diet. Usually, for the ambulatory patient, a 1200 mgm. sodium diet is effective but not too unpleasant. The physician must offer moral support and exhibit a high degree of salesmanship if he is to overcome the acquired prejudice against salt-poor food. People can live in good health with no additional salt in their food. This was illustrated by the Tlascalan nation of old Mexico who, at the time of the Spanish conquest, had lived for generations with no salt other than that naturally occurring in food. They had developed a taste for bland food and would not add salt when it was offered to them.⁶ If severe salt restriction is imposed, ammonium chloride or potassium chloride should be admin-

istered. Sodium depletion without antecedent chloride depletion is unlikely; however, with a restricted diet, periodic serum sodium or chloride determinations should be made.

The mild case of mitral stenosis with congestive heart failure responds uniformly well but the more severe case requires careful consideration. The additive value of all measures is illustrated by the case of a 56 year old white male who entered the hospital with a history of known rheumatic fever in childhood, and the murmur of mitral stenosis since the age of 30 years. For the 10 years preceding admission he had taken digitalis because of shortness of breath and for six months he had had progressive swelling of ankles and legs. Before admission his physician had produced diuresis with mercurials, but because of coupled heart rhythm had discontinued digitalis. On admission he had pitting edema to the sacrum, moist rales at both lung bases, severe orthopnea and a coupled heart rhythm as well as classical signs of mitral stenosis and mitral insufficiency. His serum electrolyte pattern was normal. The electrocardiogram showed right axis shift and frequent premature contractions. Therapy at first consisted only of bed rest, then successively a 200 mgm. salt diet, ammonium chloride followed by mercurial diuretics, and finally digitalis (Figure 1).

The course (Figure 1) shows that, with each new measure, a definite diuresis occurred indicated by a step-wise decrease in weight. Finally his weight became constant at a "dry weight" level and after discharge increased only slightly while on a fairly strict therapeutic regimen. This patient was able to maintain a good state of compensation for a long period. However, when patients are discharged before reaching this "dry weight" they usually relapse before very long, and have frequent hospital admissions.

The course of a much more seriously disabled patient is illustrated in Figure 2. This 48 year old woman gave a history of fourteen years of increasing evidence of congestive heart failure on the basis of mitral stenosis, mitral insufficiency, and aortic stenosis. About one year prior to admission she underwent mitral and aortic valvuloplasty operations following which there had been a steady decline in her functional status until, on admission to the Woodruff Center, she had anasarca, severe dyspnea at rest, and orthopnea in spite of intensive treatment at home. Because of the gravity of her condition a full therapeutic regimen was begun at

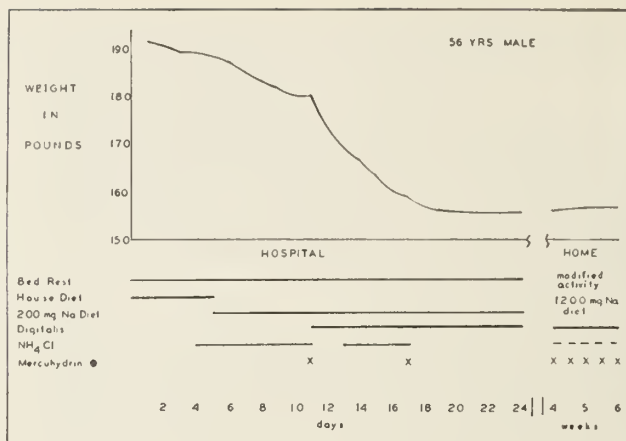


FIGURE 1

Upper curve represents the patient's weight plotted daily during hospital admission, weekly during home period. Days and weeks are indicated at the bottom of the chart. The horizontal lines after specific therapeutic measures indicate the period during which those measures were used. Mercurial injections are indicated by an "X"

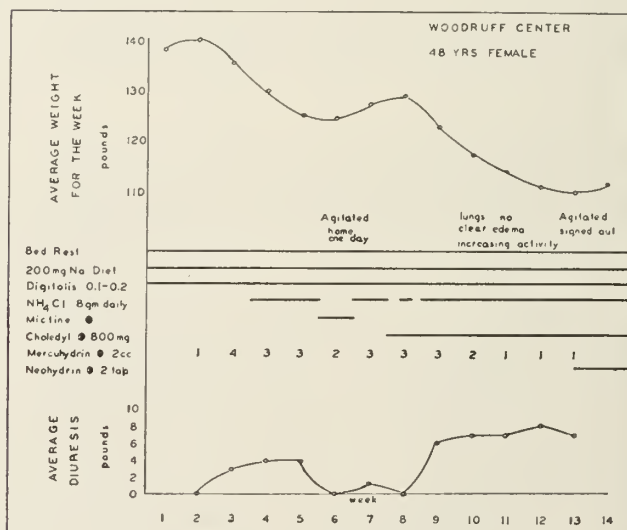


FIGURE 2

The upper curve is the patient's weight plotted as a weekly average; the lower curve indicates the average diuretic response to a single mercurial injection for each week, expressed as weight loss. The horizontal lines after specific therapeutic measures indicate the period during which those measures were used. The numbers after "Mercurydrin R" indicate the number of 2 cc. injections given each week

once, but initially there was no response to mercurials although her serum chloride level was only slightly depressed. She was very unstable emotion-

ally and the first aim was to enlist her cooperation in the program.

Once she had accepted the prospect of long term treatment and adapted to hospital life, improvement was impressive. The stage of adaptation lasted about two weeks; from then on progress was interrupted only once when she was threatened by a divorce proceeding (fifth week). The patient became quite agitated at that point and demanded a 24 hour leave of absence. Eventually the domestic difficulties were resolved and she settled back into her course of improvement, but during the episode (fifth, sixth, and seventh weeks) she lost ground as is reflected in the weight gain and failure to respond to mercurials shown on the chart. Finally in the twelfth week, she appeared to have reached a "dry weight" and was allowed increasing activity in the Occupational Therapy Department with emphasis on household work simplification. At this point domestic issues again arose and the patient signed out of the hospital against medical advice. Subsequent inability to adhere to her program at home together with emotional difficulties led to increasing signs of congestive heart failure.

Both of these patients had been refractory to ordinary treatment at home, but on prolonged hospitalization both showed a gratifying response. In the case of the last patient, one of the physician's greatest problems, emotional instability of the patient, proved to be an overwhelming obstacle to recovery even though a satisfactory physiological response to therapy was demonstrated.

Other diuretic agents are often useful, and, above all, during stages of severe heart failure, oxygen inhalation should not be forgotten. Finally, excessive peripheral edema may be rapidly eliminated by maintaining the patient in a sitting position with the feet in a tub after scarifying the dorsal surfaces of both feet by making transverse incisions through the skin. In this way up to 10 or 12 liters of edema fluid may be removed each day.⁷

COMPLICATIONS OF THE DISEASE

Among the complications of mitral stenosis other than congestive heart failure, recurrent acute pulmonary edema, hemoptysis, and arterial embolism associated with atrial fibrillation are the most troublesome. Subacute bacterial endocarditis still occurs but the use of antibiotics, particularly at the time of tooth extraction, has undoubtedly reduced this risk to a low level. However, the increasing

incidence of antibiotic-resistant hemolytic *Staphylococcus aureus* may once again make endocarditis a major threat to the patient with rheumatic heart disease.

The management of acute pulmonary edema, when it occurs because of mitral stenosis, is the same as for pulmonary edema from any other cause. Morphine, aminophyllin, and oxygen (preferably by inspiratory positive pressure) are the basic therapeutic tools. However, some effort should be made to help the patient avoid these episodes. The three most important features of management are: 1, a good basic program to maintain cardiac compensation; 2, a way of life that avoids as much as possible excitement and excessive effort; and, 3, sleeping on several pillows and interrupting sleep by short periods of sitting up once or twice a night.

Hemoptysis often worries the patient more than acute pulmonary edema and it may be exsanguinating. It is usually infrequent, and the patient should be given firm reassurance that he will not bleed to death even though the danger does exist. Fear in itself seems to aggravate pulmonary bleeding. Sedation and mild cough suppression are indicated. In cases of massive hemorrhage the patient should be asked whether he can tell where the bleeding point is. Occasionally he can do this and the affected side should be kept down, thus allowing gravity to help localize the blood and prevent flooding of other lobes.

Although there is no specific preventive for hemoptysis, the condition itself may be self limiting. Some patients will have numerous hemoptyses early in the course of their disease followed by a long hemorrhage-free interval.

Although many patients with rheumatic mitral stenosis develop atrial fibrillation, and mural thrombi are frequently found in the left atrium at autopsy or operation, relatively few develop arterial embolism of clinical significance. However, when it does happen it can be disabling. One approach to the problem is to maintain the best possible state of compensation, remove peripheral emboli when possible, and plan a program of rehabilitation if hemiplegia occurs. This program is not active enough to satisfy some physicians who must then choose surgical removal of the auricular appendage, prolonged anticoagulation therapy, or both. The former often does not completely remove the clot and the latter is difficult and hazardous. If an attempt were made to convert fibrillation to regular sinus rhythm early

in its course by means of quinidine, success could be expected in a high proportion of cases, and the problem of embolism would diminish. The danger of dislodging a large clot at the time of conversion must be slight indeed as few physicians have actually witnessed such a catastrophe.

SURGICAL MANAGEMENT

Since this is a discussion of medical management nothing has been said about the surgical approach to the valve itself. At the present time evaluation of surgical measures is difficult because of the constantly improving surgical techniques and the relatively short follow-up period since the first operations on acquired valve lesions. Whatever the future of surgical management of mitral valve disease may be, however, the internist must always bear two important points in mind. First, the disease is never limited to the valve alone, hence it cannot be cured by treating only the valve, and, second, any surgical procedure should be preceded by a period of optimal medical treatment.

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NEUROFIBROSARCOMA OF THE CHEST WALL

A Case Report

WARREN ZEPH LANE, M.D., *Darien*

NEOPLASMS of the chest wall are not frequent. The world literature, now summarized to 1953 by Hochberg and Rivkin,¹ appears to indicate that about half of the reported cases are sarcoma. The earliest report of Hedblom² was published at the dawn of thoracic surgery in the United States, at which time 313 cases had been gleaned from the literature. With the more widespread distribution of thoracic surgeons since 1950, and the concomitant availability of safe anesthesia and ancillary services, the next survey of the literature should reveal a greater number.

Whether benign or malignant, the neurogenic tumors of the chest wall produce symptoms which are characteristic only after the lesion is fairly advanced in evolution. The usual complaint is of pain at the site, and radiation of pain along the distribution of the nerve. A palpable tumor, which is tender to pressure or to compression of the affected ribs from the costal margin, is sufficient evidence to seek a definite diagnosis. The roentgenograms of the chest are usually characteristic and present a circumscribed area of density confluent with the chest wall. Tomography is seldom necessary for localization of the neoplasm. If the lesion is well advanced, contiguous organs may be involved to produce symptoms or to demonstrate bony erosion. The differential diagnosis can rarely be settled without a biopsy and because of the high incidence of sarcoma, this procedure would be done with a full complement of instruments for the definitive treatment.³ Local excision should not be considered when such a lesion presents for surgical treatment.

The treatment, therefore, is surgical excision based on the concept that surrounding normal tissues must be excised to encompass the tumor. If a frozen section is equivocal it is better to proceed toward the more extensive removal because of the pre-

The Author, *Assistant Surgeon, Stamford Hospital, Stamford, Connecticut*

SUMMARY

A case of neurofibrosarcoma of the chest wall is presented.

Radical excision has resulted in two years freedom from disease, an excellent cosmetic result, and no disability.

viously stated incidences of sarcoma and because of the poor prognosis of the malignant neurosarcoma.⁴ The incision should be planned so that *en bloc* removal of tumor is accomplished with skin and subcutaneous tissue overlying the lesion. Entry into the pleural space is necessary to establish the extent of invasion or size of the intercostal portion of the tumor. Preliminary planning for use of fascia lata, skin grafts or prosthetic wire gauze will make the procedure more orderly. It goes without saying that adequate blood transfusions and expert assistants are essential.

The following case report is illustrative of the foregoing remarks:

Mrs. O. A., a 25 year old Negro female, was admitted to Stamford Hospital for the first time on July 18, 1955 complaining of a lump over the right anterior lateral chest which had been present several months. Her mother and father died of natural causes. She denies previous admissions except for two term births; the children are living and well. She smokes and drinks moderately.

The mass found by the patient was gradually enlarging without pain and on advice of her physician she was admitted for removal. Excision was performed on July 19, 1955 under general anesthesia and on section was found to be a neurogenic sarcoma. On October 24, 1955 the patient was admitted for the second time complaining of severe pain in the area of excision, increasingly lancinating with a dull ache at other times which was only partially relieved by opiates. On examination no mass was found and the

From the Tumor Clinic and Department of Surgery, Stamford Hospital, Stamford, Connecticut



Right Lateral View 12-6-55

Note double density above diaphragm anteriorly which demonstrates extent of tumor



Roentgenogram just before operation, dated 12-6-55

The lack of x-ray findings is characteristic

patient was discharged to be followed by the Tumor Clinic. On December 5, 1955 the patient was readmitted for the third time because a palpable mass was present and pain had persisted.

On physical examination the patient was a well developed and well nourished Negro female who weighed 131 pounds. Her blood pressure was 128/96, pulse 82, respiration 20, and temperature 99.8(F). The only positive physical finding was a three inch healed scar over the anterior tenth rib. There was a 4 cm. $\times$ 2 cm. hard mass between the 9th and 10th ribs which was slightly tender.

Laboratory findings: White blood count 6,800 with a normal differential; red blood count 4.00 million, hemoglobin 12.2 Gm., 71 per cent; hematocrit 36 per cent; urine, specific gravity 1.026, with a trace of albumin and many white blood cells and five red blood cells per high power field; a trace of albumin; subsequent urines were negative. Alkaline phosphatase 4.0 SJR units; calcium 9.2 mg. per cent, phosphorus 3.2 mg. per cent, total protein 6.5 Gm. per cent; stool was negative for occult blood.

On December 12, 1955 with intratracheal nitrous oxide, oxygen and ether anesthesia the lesion was excised. The eighth interspace was entered and the tumor found to involve the diaphragm and transversalis muscle; projecting through the interspace in a "collar-button" manner so that the major portion was intrathoracic. There was no evidence of lung involvement and palpation of lung and hilum was negative. The tumor was removed widely by resecting the posterior portion of the 9th, 10th and 11th ribs, dome of the diaphragm, and costal attachments of the transversalis



Roentgenogram of chest dated 6-6-56

Minimal chest deformity is associated with no gross change in respiratory function

muscle. A wide margin of skin and subcutaneous tissue was excised with the tumor.

The defect produced by this excision was extensive. The upper abdomen was explored and no disease was palpable. A large sheet of fascia lata from the right thigh was excised from the previously prepared site. Closure was accomplished by suturing the posterior and medial portion of the paralyzed diaphragm to the intercostal muscle and periosteum of the eighth rib. The strip of fascia lata was then utilized to close the remainder of the diaphragm and the anterior abdominal wall. Flaps of skin were undermined and closure was obtained without tension. Silk technique was used throughout. The chest was drained through the posterior 6th interspace with a #26 Foley catheter.

Following operation the chest wall was stable and the chest drainage was discontinued on the third day. The wound healed per primum and all sutures were removed on the 10th day. About 80 cc. of serous fluid were

aspirated from the wound just before discharge. In the clinic aspiration was done once more and the wound has since remained stable. Radiographic examination is normal except for absent ribs and the patient at the two year follow-up has no pain, is able to work, and is quite satisfied with her progress. There is no evidence of ventral hernia at the site of the large abdominal defect.

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POISON CONTROL CENTERS

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The Author. *Chairman of the Subcommittee on Poisoning of the American Academy of Pediatrics' Accident Prevention Committee; Member of the American Medical Association's Committee on Toxicology*

IN 1951 the Accident Prevention Committee of the American Academy of Pediatrics made a nation-wide survey of pediatric emergencies handled by a representative sample of pediatricians. The survey revealed that most of the emergencies these physicians handled were associated with accidental poisoning, in which children had swallowed substances that were not intended to be eaten.

Stimulated by this finding, the Illinois Chapter of the American Academy of Pediatrics started a poison control center in Chicago. In several places in the United States there was a group especially interested in gathering information on the treatment of poisoning, or on the toxic constituents of common household products, but these groups usually resolved around a single individual, university, or other institution or agency.

The group at the Chicago center was the first one to be organized as a cooperative and integrated community activity, and the first to include prevention as well as treatment of poisoning in its activities.

The Chicago center combined into a single coordinated program the efforts of the pediatric departments of all five medical colleges in that city, the Chicago Board of Health, the State toxicological laboratory, the Crippled Children's Division of the University of Illinois, and six of the city's major teaching hospitals. Its advisory committee included representatives of the American Medical Association, the National Safety Council, the Federal Food and Drug Administration, and representatives of the city and state institutions mentioned earlier.

This group helped organize the center and collated a summary of references on the basic toxic constituents found in the thousands of materials that could be swallowed in the average household. It also developed for each of the participating hospitals an outline of the best current knowledge of treatment for ingestion of the poisonous substances listed in the summary.

In each member hospital an attending pediatrician was designated as poisoning control officer, or liaison to the central committee. He was responsible for seeing that the necessary equipment and supplies were readily available in the respective emergency rooms. He was responsible, also, for orienting the intern and nurse on emergency room duty and others of the hospital staff to the poisoning problem, and for seeing that a report of the treatment and response of all cases coming in was made to the Chicago Board of Health.

An epidemiologist from the Chicago Board of Health was assigned to work with the advisory committee, and the Board recruited a public health nurse to aid in the follow-up work of all reported cases of accidental poisoning. Her follow-up report and the original report of the hospital treatment of the poisoning were tabulated mechanically, and the resulting information (the types of substances that had been swallowed, factors associated with their ingestion, the treatment, and the results obtained) was made available to each member of the advisory committee, to the participating hospitals, and to others involved in treatment and prevention. More complete details of this program have been published in professional journals.^{1,2}

The center's trial period was quite successful, and the idea spread to the other five full-time health departments in Cook County. They did not assign just one member of the staff to make follow-up visits, but incorporated that activity into the department's total program. This still meant using the public health nurses predominantly for home follow-up visits; eventually, the Chicago Board of Health also transferred this function to its regular staff of public health nurses.

GROWTH OF THE CENTERS

Poison control centers with similar objectives of prevention and treatment have since developed in many other cities. They differ in many administrative details, but preserve the general principle of sharing centralized sources of information on treating and preventing poisoning.

By November 1956, 23 cities were known to have such centers in operation. They are located in: Atlantic City, New Jersey; Baltimore, Maryland; Boston, Massachusetts; Chicago, Illinois; Dallas, Texas; Denver, Colorado; Durham, North Carolina; Grand Rapids, Michigan; Harrisburg, Pennsylvania; Indianapolis, Indiana; Kansas City, Missouri; Louis-

ville, Kentucky; Memphis, Tennessee; Milwaukee, Wisconsin; Montclair, New Jersey; Newark, New Jersey; New Bedford, Massachusetts; New York, New York; Oklahoma City, Oklahoma; Phoenix, Arizona; Seattle, Washington; Springfield, Illinois; and Washington, D. C.

In addition, the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society in cooperation with the Florida Board of Health have recently announced that a statewide network of poison control centers has been established in 15 Florida cities and towns. Other centers are in various stages of development in many other cities throughout the country.

Recent reports from centers in 13 cities reveal that of 3,877 cases, 2,532 were in children under five years of age. Of these, 955 children ingested internal medications—*aspirin*, laxatives, and sedatives—in which death resulted for three children; 188 ingested external medication nonfatally; and 1,389 ingested cleaning agents and other chemicals.

Of the last group, 17 were fatally affected by the materials ingested which included lye, kerosene, other petroleum distillates, pesticides, paints containing lead, and some unknown substances.

ORGANIZATION OF THE CENTERS

The organization of these centers varies with the medical and related facilities of the communities they serve. The administration of the program may be the function of a health department, a hospital, a medical college, a local medical society, or a combination of these. There may be only one agency taking part in such centers, or there may be over a hundred different agencies and institutions.

The general purpose of the centers is to minimize the damage to children from ingestion of potentially toxic substances; to coordinate the various types of general and specific treatment measures required in the hospital, the physician's office, and the patient's home; and to make resources for treatment more readily and widely available.

The stimulation of both clinical and basic research to improve methods of treatment following ingestion of these potentially toxic substances is an additional objective. Methods of making the initial treatment (primarily first aid) more prompt and effective usually are included in most of the centers.

In the area of prevention, the specific objectives may include the development of more complete

information regarding the distribution, type, and toxicity of the various poisons, as well as the circumstances in which the poisons are likely to exert their deleterious effects.

Measures for evaluating and disseminating information about the most effective preventive measures, with the aid of various professional and lay persons and groups throughout the community, should be an integral part of the activities of such centers.

NURSING ACTIVITIES IN FOLLOW-UPS

The follow-up home visit to a poisoning victim often provides an opportunity for the nurse to offer other nursing services. Frequently she does this by inquiring how the patient has been getting along since leaving the hospital, asking if any additional care or treatment is required, then asking about the circumstances of the poisoning incident.

The nurse is careful to avoid increasing or exaggerating the mother's guilt, but she discreetly shows the mother how this and other poison hazards can be minimized. The nurse then guides the conversation to general accident prevention. She may comment on any overt hazards she has noted, and frequently she leaves a home safety check list for the parents to fill out. Following this, or at the same time, if it seems feasible, she may discuss immunization, child health conferences, or visits to the family physician, prenatal care, or detection of chronic disease.

The home visit is not concerned only with the unpleasant performance of placarding for a communicable disease, or detecting cases, or finding contacts as in tuberculosis or syphilis; it is related to friendly concern for the child recently released from the hospital, and it naturally becomes a helpful general health visit.

In some of the centers, sanitarians, physicians, and other health department personnel make such home visits, in addition to public health nurses. In others, unfortunately, the health department takes no part and there are no follow-up home visits.

MENTAL HEALTH ACTIVITY

Few, if any, of the centers have developed mental health activities in relation to intentional poisoning. Although more than twice as many persons die annually as a result of intentional poisoning as succumb to accidental poisoning, there is practically no organized public health activity directly related

to this problem. Moreover, for every successful suicidal poisoning, there are probably at least several unsuccessful attempts. This is a problem of major proportion. It is quite possible that an expedient as simple as a visit to the home of an adult who has been recently treated for poisoning (whether officially labeled accidental or suicidal) may prevent a second attempt. This might present difficulties because of the social stigma and secrecy that is often attached to self-inflicted poisoning. But, if the follow-up visits were made discreetly by nurses, social workers, or others with special psychiatric orientation, they might result in referrals to psychiatric service. They might even benefit merely by encouraging the family to watch the patient more closely while his grief or frustration is acute. It might be helpful if the patient could unburden himself of his fears and anxieties to a sympathetic nurse or social worker.

Many cases of threatened suicide reported by clinics or private physicians (if reporting were encouraged) might benefit from a visit by a properly trained or oriented public health nurse. A case-finding program for incipient suicide might save as many lives as a similar program for heart disease. The role of the public health nurse is gradually changing. The part she plays in many of the newly developed poison control centers that are springing up in cities throughout the country is an excellent illustration of this. Her fundamental function of teaching health and carrying out medical recommendations in the home remains, but the focus of her function shifts gradually as the scientific and medical frontier advances. As immunization and antibiotics are used more commonly and prepared baby foods and formulas become simpler and more readily available, the public health nurse's emphases and duties gradually shift from communicable disease nursing and preparing formulas to mental health programs, chronic disease activities, and accident prevention programs. She can be especially helpful in accident prevention programs in which poisoning holds a high place.

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THE CONNECTICUT HAZARDOUS SUBSTANCES LAW

HARRY J. FISHER, PH.D., *New Haven*

The Author. *Chairman, Connecticut Advisory
Committee on Foods and Drugs*

ON May 15, 1957 Governor Ribicoff signed Public Act No. 271, "An Act Concerning the Labeling of Hazardous Substances," thus bringing to a successful close a campaign started two years before by the then Connecticut Committee on Foods, Drugs, Cosmetics and Devices. Before explaining the detailed provisions of this law, I should like to outline briefly the history of the birth of the idea of such a law and of the subsequent legislative vicissitudes of that idea before it finally became embodied in a Connecticut statute.

The late William T. Salter, M.D., who was the original chairman of the Connecticut Committee on Foods, Drugs, Cosmetics and Devices when that joint venture of the professional societies in the fields of medicine, dentistry, veterinary medicine and pharmacy was started nine years ago, had aroused in the Committee almost from its first days an interest in the problems of the physician whose patient (usually a small child) had swallowed some household product of unknown composition that might or might not be poisonous. At that time the Committee was thinking in terms of the preparation of an alphabetical catalogue of such products by brand names, with the active ingredients and suggested type of treatment listed after each brand; the intent was to distribute these lists to the emergency rooms of hospitals. With the aid of the State Department of Health a relatively incomplete list was actually prepared and published in the July, 1955 *Connecticut Health Bulletin*, but the Committee's enthusiasm for further pursuit of this method of attack on the problem became weakened by its discovery that not only would many thousands of brand-name products have to be covered but the ingredients of any one preparation might at any time be changed by the manufacturer without notice of any kind.

Late in 1954 the Committee's attention was attracted to the then recent adoption by the New York State Department of Health of regulations requiring certain household products to be labelled "Poison" and to carry ingredient and antidote statements. It occurred to the Committee that if a law could be passed in this State that would make it obligatory for manufacturers of all such preparations to place on their labels the type of information the Committee had been trying to compile, such a law would accomplish the sought-after purpose of supplying information to physicians in emergencies more efficiently than could any card index, both because the information on how to treat a child who swallowed some household product would be instantly available and because there could be reasonable confidence that that information actually applied to the contents of the bottle that was swallowed rather than to some earlier formulation of the same brand name but different composition. At this time Desmond D. Bonnycastle, M.D., who represented the Yale University School of Medicine on the Committee, informed the other members that his friend Representative J. M. Turner of Bethany would introduce a bill to accomplish these objectives in the 1955 General Assembly if the Committee would agree to stand back of it. At its meeting on January 27, 1955 the Committee voted unanimously to sponsor a bill drawn up on the lines of the New York regulations. When the legislative committee hearing on this bill was held there was no open opposition, and the Committee members in their innocence of the ways of politics thought that the bill was due for passage without opposition. They were soon disillusioned. The details concerning what happened are controversial; suffice it to say that the General Assembly finally voted to refer the whole subject to the Legislative Commission with directions to present its recommendations to the 1957 legislature.

Compressing the account of subsequent events into as few words as possible, before the new legisla-

ture met in 1957 the Committee and the Manufacturers' Association of Connecticut got together on a revised bill that both could support, this bill was turned over to the Legislative Commission, and the Commission submitted to the 1957 General Assembly a report recommending passage of essentially the same bill. In the meantime representatives of the Manufacturing Chemists' Association and the Chemical Specialties Manufacturers' Association had met in New York City and drawn up a bill whose chief difference was that it was written in terms of hazardous substances rather than of hazards as was the Legislative Commission bill. This bill was introduced into the legislature "by request," and it was an amended form thereof, upon which eventually everyone compromised, that was reported out by the Committee on Public Health and Safety and passed by the General Assembly on May 15. The day following adoption of the new law, the legislature passed unanimously a resolution of tribute to Dr. Salter which ended as follows:

"Whereas, Dr. Salter tragically did not live to see the fruition of his efforts, yet his leadership, determination and idealism inspired others to carry on the battle which resulted in the 'Labeling Bill' now enacted into law,

"Now, Therefore, Be It Resolved, that the General Assembly of Connecticut does hereby humbly express its profound respects to the memory of Dr. Salter, now that one of his lifetime objectives has belatedly come to successful fruition, and

"Be It Further Resolved, that copies of this resolution be sent to his widow and daughters and to the President of Yale University."

Just what does this law do?

First, it is purely a labeling law; it confers no authority on the enforcing agency (the Food and Drug Commission) to forbid the sale of any substance (or mixture of substances) whatever, so long as the container bears the statements that the law requires.

Second, the law applies only to products containing substances which are hazardous under its definitions; all nonhazardous preparations are wholly exempt from the provisions of the law.

The original primary purpose of the sponsors was to require manufacturers to supply certain information for physicians' use in emergencies: the names (and preferably proportions) of the ingredients and of such antidotes to these ingredients as

might exist. The reason for the antidote provision was that it was believed that the ordinary physician could not be expected to be informed on how to treat poisoning with all of the newer synthetic compounds constantly coming on the market, and should be supplied this information by the manufacturers. Unfortunately (as we believe) the American Medical Association objected to anything but "first aid instructions" appearing on the labels, and such instructions are consequently all the law now requires. To this extent the law is now directed toward helping the layman rather than the physician as was originally intended.

The law is restricted to products "intended for general home or household use," and does not enter into the field of labeling of chemicals used in industry. Preparations coming under the Food, Drug and Cosmetic Act and the Insecticide and Fungicide Law are also exempt, on the theory that in these fields the present laws already provide sufficient safeguards. Finally, soaps and allergenic substances are excluded.

Having defined those products that the Hazardous Substances Law does not cover, let us see what it does require of all the numerous household articles that are not foods, drugs, cosmetics or pesticides but that do contain hazardous ingredients:

The labels of all such products must bear:

(a), The name and place of business of the manufacturer;

(b), The "chemical, common or recognized generic name, not the trade name only, of the hazardous substance or of each component which contributes substantially to its hazards;"

(c), A "signal word indicating the degree of hazard as follows: 'DANGER' for those products presenting the most serious hazards, 'CAUTION' for those products presenting the least serious hazards and 'WARNING' for those intermediate between 'DANGER' and 'CAUTION'."

(d), "An affirmative statement of the principal hazard or hazards when necessary such as 'Flammable,' 'Vapor Harmful,' 'Causes Burns,' 'Absorbed Through Skin,' or similar wording descriptive of the hazard;"

(e), "Precautionary measures describing the action to be followed or avoided;"

(f), "Instructions when necessary as to first-aid treatment in case of contact or exposure, if the substance is hazardous through contact or exposure;"

(g), "The word 'POISON' for any substances which are defined poisonous;" and

(h), "Instructions for handling and storage of packages or containers which require special care in handling or storage."

The term "hazardous substance" is defined by the law to include "any substance which is toxic, corrosive, an irritant, flammable or which generates pressure through decomposition, heat or other means and which may result in substantial personal injury or illness during any customary or reasonably anticipated handling and use." Any substance "which has the inherent capacity to produce bodily injury through ingestion, inhalation or absorption through the skin" is classed as toxic, and corrosive substances are defined as those "which in contact with living tissue will cause substantial destruction of tissue by chemical action." The definition of "irritant" is: "any substance, which in contact with normal living tissue will induce either immediately or after prolonged or repeated contact a severe local tissue reaction not leading directly to the destruction of tissue." Any substance having a flash point of 80° F. or below is classed as "flammable," with a rather technical exception to take care of certain aerosol products.

The lengthiest definition is that for "Poison;" in effect it draws the line between substances poisonous and nonpoisonous by swallowing at an acute median lethal dose of 50 milligrams per kilogram for white rats "weighing between two hundred and three hundred grams," and classes as poisonous by inhalation those which kill rats of the same size within 48 hours "when inhaled continuously for a period of one hour or less at an atmospheric concentration of two milligrams or less of gas, vapor, mist or dust." Substances are considered absorptive poisons when they produce "death within forty-eight hours in half or more than half of a group of ten or more rabbits tested in a dosage of two hundred milligrams or less per kilogram of body weight, when administered by continuous contact with the bare skin for twenty-four hours or less." There is a general provision, however, that "If available data on human experi-

ence with any substance in the above named dosages or concentrations indicate results different from those obtained on animals, the human data shall take precedence." Incidentally, the most serious controversy over the wording of the law involved this poison definition section; the attorney for the Chemical Specialties Manufacturers' Association insisted on phraseology for another section which would have had the effect of preventing the Food and Drug Commissioner from enforcing the law against any product unless he had made his own pharmacological tests of that specific product—even if it were known that the preparation was loaded with cyanide. Eventually language was adopted that permitted the Commissioner, when he had "reason to believe" that a poison was present, to require an article to be labelled "Poison," etc., unless the manufacturer himself could produce evidence "that such substance is not a poison as defined in this act." In other words, the burden of proof is placed on the manufacturer and the State is not required to spend large sums for pharmacological testing in order to enforce the law.

Besides the provisions outlined here, the law includes other sections which are important for its enforcement but are of lesser interest to the general reader: embargo provisions, type size specifications, the mechanics of holding hearings on proposed regulations, court prosecutions, penalties, etc. Incidentally, the maximum penalties for violation of the law are a \$500.00 fine and six months in jail. The law goes into effect on January 1, 1958, and (as was stated before) its administration is entrusted to the Food and Drug Commission.

Any entirely new law such as this is has to be on the statute books for at least two years before it can be known whether it will accomplish everything it was intended to or whether it will be partially nullified by some unanticipated loophole. The sponsors have serious hopes that the new Hazardous Substances Law will play an important part in saving the lives of some—and perhaps many—children (even adults) in the years to come. It will not prevent all accidental deaths by poisoning—that was never expected—but it is one step in that direction.

TREATMENT OF DIAPER RASH

FRANK LEONE, M.D., *Danbury*

The Author. *Instructor in Dermatology and Syphilology, New York Polyclinic Medical School and Hospital, New York City; Attending in Dermatology, Danbury Hospital, Danbury Connecticut*

SUMMARY

A total of sixty (60) cases of diaper rash were treated with Bur-Veen solution and Aveeno ointment. In 57 cases the condition showed excellent response with relief from burning, pruritus and irritation. In three cases, however, additional therapy was required for existing pyoderma.

Burow's solution and an oatmeal colloid, is used as a lukewarm wet dressing or sitz bath for several minutes, twice daily. After the soak the skin is patted dry. These applications and baths allay the inflammation, reduce swelling, dry exudation and stop the itching and burning. This is followed by Aveeno ointment,* an improved Lassar's paste type of preparation which is protective, adsorptive and bacteriostatic.

It is suggested to the mothers that Bur-Veen solution be used to sponge and cleanse the soiled tender skin of the infant with each diaper change to avoid further irritation. Then they are instructed to apply a light coating of Aveeno ointment to the involved areas, prior to putting on a clean diaper. This protects the affected area and reduces the possibility of secondary infection.

In a series of sixty (60) cases of diaper rash treated with Bur-Veen solution and Aveeno ointment, all but three cases responded with satisfactory results. There was no evidence of exacerbation or sensitization. The other three cases required more specific treatment for an existing pyoderma.

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It is uncommon to find an infant who at some time does not have an irritation or inflammation of the diaper region. This condition is seen as an erythematous and papulovesicular dermatitis which in many cases shows superimposed bacterial or monilial superficial infection. It begins with a patchy, localized, irritated, papular condition which soon spreads, often involving the genitals, arms, buttocks, lower abdomen, inner thighs and sometimes even the legs and heels. In severe cases there may be considerable oozing, maceration and ulceration.

This condition is brought about by exposure of the diaper area to prolonged contact with urine and feces. This may be further aggravated by wearing of plastic or rubber waterproof garments which increase the macerating effect of the warm wet contents.

One theory that has been advanced to explain the etiology is that bacteria found in the intestinal tract and feces decompose the urea found in the urine, forming ammonia. The ammonia, in turn, causes irritation and burning of the skin. However, repeated contact with the moist contents of the diaper, even without the breakdown of urine, can produce many of the problems seen in this area.

Diaper rash is also probably the most overtreated skin condition in infancy, with eczematization often seen from improper treatment.

TREATMENT

The regimen presented herewith is simple and efficient. Absolute cleanliness is necessary. Diapers should be changed as soon as possible after they are soiled. Disposable diapers are best. Avoid the use of heat and moisture-retaining materials such as rubber sheeting and plasticized diapers. These increase maceration and sweat retention. The washing and treatment of diapers by diaper services offers an excellent means of thorough rinsing and sterilization.

Wet dressings provide a very efficient treatment for this condition. The use of Bur-Veen* wet dressings is preferred. Mothers like it because it is easy to prepare, convenient, and does not stain. In the acute phase, Bur-Veen, which is a combination of

*Bur-Veen Wet Dressing Powder and Aveeno Ointment was supplied by Aveeno Corporation, New York 19, N. Y.

REHABILITATION — CHALLENGE AND RESPONSIBILITY

W. SCOTT ALLAN, *Boston, Massachusetts*

The Author. *Supervisor of Medical Service, Liberty Mutual Insurance Company*

WE hear a great deal these days about rehabilitation—the word is used loosely to apply to everything from the recovery process of the mentally ill to public housing. However, in the sense that it is most commonly used, it refers to a combination of techniques and specialized facilities which are combined to provide physical restoration, emotional adjustment, vocational counseling and job placement.

Beginning over fifty years ago with the development of programs for the training of crippled children, the modern trend of rehabilitation encompasses the specialized services of physical restoration, psychological adjustment, personal counseling and vocational training and placement. The provision of such services often involves the work of a number of agencies, both public and private. Coordination and extension of complete rehabilitation services for the benefit of a larger segment of the population have become paramount problems for those interested in this field.

THE REHABILITATION CENTER

It had long been evident that some sort of specialized facility was needed to support the progress of recovery from the time a seriously injured person left the hospital following surgery and convalescence until he reached the stage of being able to return to work, or at least to care for his own needs at home. That facility and service have now been generally incorporated into what we call a rehabilitation center. The national Conference of Rehabilitation Centers has defined a rehabilitation center as:

A facility which assumes responsibility for evaluating the needs and capacities of disabled persons and for providing appropriate individualized services of a medical, psychosocial and vocational nature. The services are substantial and intensive and are

integrated with each other and with other services in the community.

The rehabilitation center, while a relatively new and comprehensive facility, is not the only kind of rehabilitation service. In-patient hospital care, departments of physical medicine in general hospitals, out-patient clinics for physical therapy, sheltered workshops, specialized institutions for chronic illness and selective physical or mental handicaps, vocational training schools, public and private service agencies in the field all contribute to the general rehabilitation process.

Neither is rehabilitation solely a matter of facilities—it is a coordinated process extending from the time of injury to job placement, from the onset of serious illness to effective self care; it encompasses the work, direction, guidance of many individuals and institutions to accomplish a final, satisfactory result.

A COMMUNITY PROBLEM

Rehabilitation of the physically handicapped is basically a community problem. While the assistance of private and public agencies, both at the state and national levels, is both valuable and desirable, the basic need is for community understanding of the problems of the physically and mentally handicapped and for concerted action based upon that understanding. The business interest in any community must necessarily become a focal point of community planning, financial support and proposed use of rehabilitation services.

The Bureau of Labor Statistics estimates that between five and six million persons of working age in this country have disabilities serious enough to present difficulties in finding suitable jobs. It is further estimated that each year, as a result of disease or accident, about 250,000 additional persons of working age become in need of vocational rehabilitation. To the organization contemplating action on any of the several aspects of the problem of the

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handicapped worker, review of such statistics and comparisons between the over-all need and the pitiful shortage of existing facilities for dealing with the problem may lead to understandable discouragement. This is especially true when considering the huge financial backing, the education of industry, labor, medicine and administrative agencies which seem necessary to attack the problem. In reality, realization of the number of handicapped in a given community, utilization of existing and planned facilities together with the specific support of interested parties, offer real opportunity for success.

RECENT DEVELOPMENTS

Within the past three years there has been a surprising number of significant developments which point the way toward the increasingly important role that rehabilitation is destined to play in the overall handling of cases involving those handicapped by injury, disease or congenital conditions.

President Eisenhower, in his January 1954 *Message to Congress*, ably highlighted the aims and interests of our country in relation to the importance of rehabilitation of the disabled worker, as well as other types of handicapped people. Congressional action to provide funds for the development of new facilities and training of specialized personnel followed closely upon the President's call and the resulting enlargement of federal-state grants for these purposes has already led to much planning for the development and improvement of community rehabilitation facilities and services. The planning and growth of such facilities and the proper utilization of them to the advantage of all concerned will call for a high degree of understanding of what can be accomplished in a practical way by sound rehabilitation methods.

The National Safety Council compilation of statistics for the year 1955 indicates that there were 1.9 million work accidents which caused a production loss of 45 million man-days and a total cost in loss of wages, medical expense, compensation benefits and other administrative expenses of \$1.8 billion. If we add to this latter figure the so-called hidden, or indirect, costs of the lost production time, it raises the total estimated cost of work accidents in 1955 to the staggering total of \$3.5 billion.

INCREASING COSTS OF DISABILITY

The growth of modern surgical techniques and

drug therapy has resulted in greatly increased life expectancy following serious injury or disease. The prolonged disability which now becomes a possibility as the result of such medical advances can result in staggering costs as far as both indemnity and medical benefits payable under workmen's compensation laws are concerned. At the present time, twenty-seven of the workmen's compensation laws provide weekly payments for as long as the worker is disabled or for life, and thirty-six of the laws provide for the payment of medical benefits for as long as they may be needed or for life. The trend toward including the degenerative conditions, such as heart disease, arthritis and the like, under workmen's compensation, together with the recognized aging of our general as well as our working populations, means greater burdens for industry and insurance in the future. Medical and surgical fees, as well as hospital costs, have greatly increased in the past ten years and there is no significant indication that this trend has ended.

Under many state laws, serious industrial injuries to a young man, such as those involving loss of both arms or legs or spinal cord damage resulting in paralysis of arms or legs, can cost between \$200,000 and \$400,000 for surgery, prolonged hospitalization and lifetime nursing care. Our own company records show that we are maintaining reserves totaling nearly \$5 million on open cases involving spinal cord injury and more than \$7 million on open cases involving heart conditions allegedly related to industrial injury. It can readily be appreciated why industrial management, labor union officials, insurance company executives, legislators and administrators regard with grave concern this steadily increasing burden on American business, on the American public and on the individual American working man. Safety engineering of machines and workers (although it has been a valuable contribution) has not provided the complete solution. The steady trend toward broader interpretation of the workmen's compensation laws and more liberal benefits prescribed by those laws holds no promise of lowering the overall costs. Where then can a solution be found which offers some hope for reduction of the costs of injury and resultant disability to industry and at the same time provides the injured worker with the best of medical attention, reduces his time away from work and lessens the permanent effects of his injury?

REHABILITATION THE SOLUTION

We are convinced that the answer lies in the direction of a sound rehabilitation program. In order to mitigate the high loss costs of present day industrial injuries, it is important that seriously injured workers receive the very best that medical skill can provide in diagnosis and surgery, as well as the best of hospital care and rehabilitative therapy. Providing these medical and rehabilitation services in addition to the minimal surgical and hospital benefits which are required by the compensation statutes constitutes an investment on our part in the reduction of disability and the restoration of the seriously handicapped to industry.

To January 1, 1956, a total of 4,057 cases had been handled by the company's Boston and Chicago Rehabilitation Centers. Of that number, 3,509 cases or 87.8 per cent were substantially improved and about 95 per cent of these were improved to the point of being physically able to work. Of the 3,509 cases improved, 2,883 or 82 per cent actually did return to work with about one-third returning to different jobs from those which they had held before the accident. The average age for both males and females was about 44, and the average length of time from injury to admission just about six months. The services of a full-time counselor in the field of job placement have resulted in a substantial percentage of the cases returning to work being placed in a different type of job. A recent survey of thirty typical injury cases processed by our Boston Rehabilitation Center indicated an average estimated saving in compensation benefits of slightly more than \$1,000, based upon effective reduction of actual lost time from work or lessening of the permanent loss of function of the injured part.

PARAPLEGIA

The most serious of all industrial injuries are those in which a fracture or dislocation of the spinal column has caused a severance of, or pressure on, the spinal cord resulting in paraplegia or quadriplegia. Up until World War II most of such cases died within days or months of the injury, from shock or from other complications. Workmen's compensation records revealed few such cases on a disability basis as they were almost all early fatalities and death benefits were paid accordingly. Modern medical knowledge, surgical skill and "wonder drug" therapy have now made it possible for most of these cases to survive the early critical

phases and to become long-term problems of medical handling and rehabilitation. These cases may require a lifetime of hospital, special nursing or attendant care unless significant methods of rehabilitation are utilized. The Veterans Administration has operated a fine program for paraplegics, teaching self-care, ambulation with crutches and braces, operation of an automobile and some forms of sedentary work. However, civilian services for such cases have lagged far behind and many doctors and hospitals still regard these cases as hopeless from the beginning and are not fully aware of what can actually be accomplished in the direction of a self-sufficient existence.

Paraplegia and quadriplegia cases are definitely on the increase in workmen's compensation. We presently have 113 open disability cases on our books; new cases are coming in at the rate of about two a month. Because of the lack of available adequate services for the rehabilitation of many such cases, we have brought most of them to Boston or New York for specialized surgery, carefully supervised hospital care by those familiar with the necessity for special nursing techniques, patient training and early bed exercise. The cases which show progress are graduated to ambulation by experts in that field and eventually to our own Centers or to other similar facilities where the final training can be given in self care, in meeting the demands of daily living and in preparing for return to work.

We have undertaken this type of rehabilitation on 102 cases and have completed our work on 86. Of that number, 37 or 43 per cent have returned to work or are in business for themselves. Of the remaining cases, 45 have been returned to their own homes or to convalescent homes and do not require hospital or full-time nursing care. Four are still in the hospital at the present time. The following additional statistics may be of interest:

RECAP OF SAVINGS

Total estimated indemnity and medical cost of completed cases if not rehabilitated.....	\$8,449,891
Total estimated indemnity and medical cost of completed cases as of this date.....	\$4,835,273
Gross estimated saving in indemnity and medical cost of completed cases.....	\$3,614,618
Cost of rehabilitation of completed cases.....	\$ 895,415
Net estimated saving in indemnity and medical cost of completed cases.....	\$2,719,203

While any estimate of monetary savings such as

those expressed above and even speculation on the effect of rehabilitation upon the future life of a given individual are necessarily theoretical to some extent, our long experience in the field of casualty insurance and particularly in the handling of workmen's compensation claims, convinces us of the practical value of our rehabilitation efforts.

REHABILITATION GOAL OF WORKMEN'S COMPENSATION

Many scholars, administrators, labor officials, medical groups, now realize the necessity for accepting rehabilitation as a goal of the workmen's compensation laws and procedures. Rehabilitation of the injured worker and his return to gainful employment should be one of the basic concepts of workmen's compensation. It is now believed by many that ways and means must be found to insure the provision of medical and vocational rehabilitation by the establishment of standards for such services. State workmen's compensation administrative groups should be endowed with authority to supervise the medical care of workmen's compensation cases and to utilize the assistance of impartial medical experts which could insure the adequacy and continuity of medical care and rehabilitation from the date of injury to maximal restoration.

Compensation authorities, insurance carriers, self-insured employers have been slow to recognize the value of utilizing rehabilitation facilities for the reduction of disability in cases involving traumatic injury. Most compensation laws do not yet require that either physical or vocational rehabilitation be provided, and only a few employers and carriers have recognized the advantages of providing such services on a voluntary basis. They have not wished to venture into the sponsorship or support of rehabilitation centers such as our own and only a comparatively few cities in the United States have medical rehabilitation facilities that can accomplish practical results in workmen's compensation cases. Within the next few years there will undoubtedly be a rapid increase in the understanding of insurance people, of industrial executives and of attending physicians in respect to the role which rehabilitation can play in effecting a more complete recovery for the victim of industrial injury. With such realization will come an increasing demand upon existing rehabilitation facilities everywhere.

The effectiveness of rehabilitation upon the residuals of traumatic injury is not exclusively confined to the area of industrial accident. Comparable

problems are presented by the huge number of severe disabilities caused by automobile accidents, accidents in the home, on the public thoroughfare and in public buildings. More liberal benefits under health and accident policies in the future may provide an opportunity for the application of rehabilitation methods to the non-occupational accident or illness coming under such policies. Insurance and business people have little understanding yet of the vast import of the extension of rehabilitation techniques and practices to these areas of future need. The ways and means must be found to develop facilities and trained personnel which can meet the growing public demand for rehabilitation services whenever and however accident or illness strikes.

RE-EMPLOYMENT

Early consideration of re-employment possibilities means much to a seriously injured employee, especially if he will be handicapped to the extent of not being able to resume his former type of work. Careful study of available jobs and of physical abilities of the employee may pave the way to effective placement. Personal interview with the injured worker regarding his outside interests and abilities often leads to consideration of job possibilities not otherwise suspected. Complete cooperation and understanding on the part of foremen or other supervisory personnel are essential if efforts at placement are to be successful. If complete retraining in another line of work is necessary because of the physical handicap, a practical solution is offered by the assistance of the insurance carrier and of state vocational agencies. Development of on-the-job apprenticeship programs sometimes provides a "learn and earn" answer to the need.

Whatever solution is eventually reached to the problem of proper placement, either by in-plant relocation or through the help of outside vocational training, the actual employment of a handicapped worker is on a sound basis only if that employment is productive for both employer and employee. The supposedly charitable gesture of "a sweeping job for old Charlie" is out of date and unrealistic in the present-day approach to vocational guidance. The proper job is one which is worthy of the individual employee's abilities and merits his real interest and attention; one which makes him an asset to the plant, to his family and to society. All available statistics emphasize that the properly placed handicapped worker is a safer, more productive and conscientious

worker than those without handicap. Insurance rates are not adversely affected by the carefully planned employment of workers who have suffered a major disability.

Business people genuinely interested in the practical application of methods by which new techniques and facilities can help their injured or sick workers now have both the opportunity and the challenge to make contributions to the humanitarian and economic goals which characterize the whole philosophy and practice of rehabilitation. Much remains to be done in the years ahead if jointly we are to meet the public demand for increased medical services of all kinds. The accomplishments of new scientific research, improved medical teaching and better treatment or therapy techniques will mean increased responsibility, increased cost for such services and new challenges for all concerned if we are to truly lead the way toward greater alleviation of human suffering and economic distress.

Perhaps few of us can yet fully analyze the significance of our concern with better medical care and rehabilitation in the light of world developments, but we can get some hint from the fact that more and more people who are in a position to know something about the matter are convinced that our efforts on behalf of the individual under a democratic form of government may in large measure contribute to tipping the scales of world opinion in our favor.

Men like Dr. Howard Rusk, Dr. Henry Kessler, Major General Maas and others have emphasized the political and economic significance of our sincere attempts to improve the health of the peoples of the world. Rehabilitation can provide the kind of sympathetic understanding between peoples and nations that is the essential foundation of any political effort toward peace. Each of us who has a part in this great undertaking, tenuous though our immediate contribution may be, can find a sense of immense satisfaction in the knowledge that people everywhere are looking favorably upon basic achievements in the field of medicine and rehabilitation, the improved medical welfare of the individual.

A JOB FOR INDUSTRY

At the same time, none of us in private business can sit snugly back and assume that some government agency or institution will find the way to do this big job. One of the discouraging aspects in the field of rehabilitation has been that although the rehabilitation services for the disabled are increasing rapidly throughout the world, the number of persons needing such services is increasing even more rapidly. We have hardly "scratched the surface" of adapting our rehabilitation knowledge to the needs of the aging in our population, the problem of the mentally handicapped and the practical conquest of the degenerative diseases. We are a long way from educating industry in the successful employment of handicapped persons on a large scale. These problems will not be met by national surveys and impressive statistics. They will be met by community interest and community action, by local planning and perceptive encouragement of programs and facilities designed to adapt rehabilitation to our practical needs. What is right for White Plains may not be the kind of program which is needed in San Jose. In this sense, rehabilitation becomes the job of every one of us, whether we represent medicine, government, industry, labor, social agencies or other institutions and organizations.

Even in this age of automation, the individual American working man is still our country's real strength and its most important commodity. The working man represents the bulwark of our national income, our purchasing power, our standard of living, the basic unit of our tax structure. Any social law or insurance system which is to prove its worth must be geared to his welfare and especially to his medical welfare.

The tragedy of human and economic waste resulting from prolonged disability of an individual worker is ironic in this day and age. The restoration of a disabled individual to a useful and productive life is a goal which is both economically and socially sound. Rehabilitation is an investment in human values, the dividends from which can be measured not only in dollars but in self respect, worth and dignity of the individual and essential gain to society.

COURTESY IN THE OPERATING ROOM

ALLAN J. RYAN, M.D., *Meriden*

The Author. *Senior Attending Surgeon, Meriden Hospital, Meriden, Connecticut*

Good manners are important everywhere in the hospital. In the operating room they are a necessity. There is no place and no other time when the surgical patient has more at stake than during the relatively short period he spends in the operating suite. The exercise of correct conduct by medical and nursing personnel facilitates good teamwork and offers proper protection to the patient during these critical moments.

The operating surgeons are the gods in this realm. Their behavior sets the tone for all who work or come there. The surgeon who does not schedule more work than he can reasonably perform in the time allotted, who arrives promptly beforehand so that he is dressed and scrubbed when the starting time arrives or the case is prepared for him, and who performs his "emergency" surgery at the time indicated for it, will always be welcome in every operating room. If he conducts himself in a dignified manner, befitting the responsibility which he undertakes, insisting on prompt and efficient assistance from his team, he will get it, and their respect as well.

Displays of bad temper ill become any physician, but they are entirely out of place in the operating room. Teamwork can be destroyed by tongue lashings, use of improper language, throwing instruments, constant complaining and undue sarcasm. Excessive good humor, particularly when accompanied by loud laughter and horseplay, breed irreverence and are apt to lead to distraction, time wasting, forgetfulness, and perhaps more serious errors.

The surgical nurses are traditionally supposed to be a hardy breed. They must certainly possess self control beyond the ordinary, and be endowed with the ability to think and act quickly. This is a poor

reason to expose them to the torrent of abuse which they sometimes receive, the off-color remarks and stories often retailed, and other minor varieties of inconsiderate behavior.

The surgeon must remember that as the leader of his team he is also a teacher. Everyone profits when he takes time to show what he is doing and explain what he wants done for him. He should be as willing to answer questions as to ask them and should not be beyond accepting suggestions and advice if they are properly offered, just as he may offer them himself.

The relationship between surgeon and anesthetist may be a difficult one and it, therefore, requires unfailing courtesy on both sides. A free communication of ideas and observations between the two parties best serves the purpose. Advance notice of his intention to open the abdomen, enter the pleural cavity, close the wound, etc., will save the surgeon time and secure him better relaxation. He reserves, on the other hand, the right to know at all times the exact condition of his patient so that he may institute remedial measures promptly or stop the surgery if it is so indicated.

The surgeon who is assisting another surgeon has a particularly difficult role to play. His ideas must be subordinate to those of the operator, yet he is duty bound to bring his own observations to the attention of the surgeon at the appropriate moment and without offending or interrupting. In general, he should not give advice unless asked for it, except if he should be assisting for the purpose of instruction.

Conversation in the operating room, except for necessary requests and answers to questions, should be the prerogative of the operating surgeon. He may employ it to instruct his team in the principles or progress of the surgery or may introduce it at less critical moments to relax tension. Constant comment during an operation is wearisome and distracting to the team.

The patient being operated upon under local or regional anesthesia should be spared all unnecessary noise and talking. The surgeon may address him frequently in explanation or reassurance, but all other extraneous conversation should be sedulously avoided. Courtesy demands that the patient should be made to feel, and correctly so, that the only issue of importance at the moment is his operation and its outcome.

When the surgeon or any other physician visits an operating room where he is not working, he may always expect to be well received if he observes correct behavior. It is not only poor technique but definitely impolite to enter an operating room where other personnel wear cap and mask, without either one. The distance which one intends to keep away from the operating table has nothing to do with the circumstance. Making unnecessary frequent exits and entrances, talking to other members of the team without first receiving permission from the surgeon, making noise, assuming precarious points of vantage on revolving stools, lamp bases and tables, and offering unsolicited advice are good ways to make oneself unwelcome as a guest in the operating suite.

Surgeons who wish to invite visiting physicians into the operating room should be sure that the guests are expected by the operating room staff, shown where to place and change their clothes and directed to the correct room, and the correct entrance to that room. Anyone who has been a visitor to a strange operating room will know how much these things are appreciated. Actually the visitor can see much more from a well placed overhead observation gallery. If local custom allows him to come on the floor, he should still be offered his choice of locations.

The pathologist is often a very necessary visitor to the operating room. If it is possible to do so, the surgeon should notify the laboratory on the preceding day if he may require a frozen section report on tissue, and as closely as possible, what time the tissue may be ready. The circulating nurse should have cap, mask and gown ready for the pathologist when he comes and whatever material he may require, such as a scalpel or scissors, small basin, identification tag for the specimen properly labeled, and a suitable container for the specimen.

It is only fair to the pathologist to give him an adequate specimen of tissue for diagnosis. Similarly it is good policy, in so far as possible, to supply him with additional tissue if he requests it. The surgeon should not embarrass him, however, by asking his advice with regard to the operative procedure.

The radiologist may also be called in consultation during the operative procedure. The surgeon and circulating nurse should then make sure that a viewing device is available and in working order. He should be notified if he is to bring films with him. If x-ray studies are to be made during the procedure, arrangements should be made with the x-ray department at least a day in advance if possible.

In the navy it is said that a tight ship is a happy ship. The operating room which has a complete set of rules of procedure which are scrupulously adhered to by all members of the medical and nursing staff is in the best position to fulfill its function of giving the patient the best surgical care quickly and efficiently. A strong "esprit de corps" based on mutual understanding and respect of the members of the operating team can best be cultivated by the constant exercise of courtesy and good manners.

HOSPITAL ACCREDITATION — ITS EFFECT ON THE HOSPITAL, THE PATIENT, AND THE COMMUNITY

ANTHONY J. J. ROURKE, M.D., *New Rochelle, New York*

The Author. *Hospital Consultant*

SUMMARY

Prior to the report of the Stover Committee of the American Medical Association House of Delegates physicians were questioning the value of hospital accreditation. Since then there has been a change of attitude. The author discusses in detail certain aspects of accreditation which he has found in his travels to be questioned by some physicians. Specifically these are stop orders, consultations, the attendance requirement, the Joint Conference Committee, and the different grades of approval.

MY subject today is Hospital Accreditation. I am reminded of a story about a man who was visiting a farm. He saw the farmer finish milking a cow, then take the pail of milk around and give it to the cow to drink. The visitor was puzzled about this and asked the farmer what it was all about. "Oh," he replied, "the cow put her foot in the pail and I'm just running it through again."

I would like to warn you that I am not going to bring you anything new today. We have discussed accreditation inside out, upside down, backward and forward, and all I am trying to do is to run it through again to see if in the repetition we can gain some educational value.

Accreditation has had a tremendous boost since you had your last annual meeting. Up to about the time of the last meeting of the American Medical Association we were finding the doctors asking such questions as: "Why should our hospital be accredited?" Does accreditation make better medicine?" "Can you tell me why someone who is a good penman and writes a beautiful record is necessarily a better doctor?" We heard such questions everywhere.

THE STOVER REPORT

This is what was happening in the medical profession in some areas up to the report of the Stover Committee in the American Medical Association at the House of Delegates. As you remember, a Committee of doctors was appointed to review accreditation. The Committee was stimulated by those people who felt that accreditation was one of domination, that it was the concept of the diseased minds of trustees and administrators who had found something to make the life of the physician more difficult. They were firmly convinced that the Stover Committee went into its job with a built-in bias,

ready and willing to bring back a report that the AMA should withdraw from the Joint Commission; but, being honest gentlemen, they felt they should go through the motions of finding out about it. They worked hard and they conferred with many people, including Dr. Kenneth Babcock, and came to the conclusion that accreditation is a good thing for medicine and a good thing for the public. They also suddenly realized what many of us had known for many years: that accreditation is a doctor's program, set up by doctors and financed largely by doctors; that the standards were formulated by their confreres in medicine.

It has been difficult for American physicians to realize that it was within their power at any time to discontinue and give up accreditation. They did not realize, as they sent their dues to Chicago, that part of the dues went to the financing of this program. This Committee courageously continued, even though it knew it would not be popular in some areas. It reported to the House of Delegates that accreditation was worthwhile, should remain, and should continue; that it was good for doctors and

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good for patients. They also added some recommendations to the Joint Commission on Accreditation of Hospitals that it review certain items. In my opinion, these items are minor and do not affect the fundamental concepts and principles of accreditation.

In doing a great deal of medical audit work throughout the country, our consulting organization found that up to the time of this report we often had great difficulty with doctors. Since the day of that report, in every audit we have done we have noticed a change of attitude. Doctors now say to us as we work with them, "How can we do this?"; or, "This particular item we've tried to get across and we can't. Dr. Rourke, do you know another approach to it?"; or, "What does accreditation mean in this particular regulation?" This attitude is very wholesome. There have been a few setbacks as we have developed this program. Some of them have come from administrators and trustees who have been anxious to force accreditation down the throats of the doctors long before they were ready for it. They skipped the educational step. They were prone to use the whip instead of the carrot, and in doing this set the program back in many areas.

WHAT ACCREDITATION MEANS

What is accreditation, what is it all for, why should we be interested in it, what is the overall philosophy? It is this. Here in America we want only the best for the people who are ill. In order to get this we are anxious that doctors work together in a participating group method so that the knowledge of one doctor in a given area may be shared with other physicians; that any consultation which might improve the patient's care or save a life should be brought to bear in that particular area. We are anxious that doctors should meditate, that they should review their past actions, and that they should be anxious to give the highest quality of care possible. We feel that all this is necessary because we know that in every endeavor, if we get together and put more brains to work, a better product will develop. The doctors are doing this and they are doing a splendid job, not yet to the extent that we would like, but it is very encouraging to hear the questions and find the interest that has been developed. There is no other profession that I know of where men get together and criticize, comment, and stimulate each other as we have asked the members of our profession to do.

Yet here in medicine, doctors, through their tissue and their records committees are willing to sit down each month and criticize, review and evaluate. Why should doctors do this and not architects and lawyers and engineers? There is a difference and there is a reason. You can build a building and make a mistake; time will eventually correct it. You can lose a law case and diminish your bank account thereby; eventually you may replenish that bank account. But you and I and the physicians and nurses in this country are dealing with the most priceless commodity that any person owns, his health and welfare, and for this reason we feel that we are justified in doing this particular type of thing.

STOP ORDERS

I would like to comment on one or two or three areas in which I find questions as I go around the country. The new regulation that has been brought out regarding stop orders has given a great deal of confusion. Many hospital administrators and boards of trustees, familiar with the stop order usually being the 24 hour order, have ordered their staffs now to order penicillin on this basis, if they have to order penicillin, and renew the order the next day and the next and the next. This was never meant by the Commission. The Commission, I understand, found in their survey work that over and over again patients were in the hospitals two or three weeks, yes, even two or three months, who had had an order for penicillin the first day of admission and at the end of the three month period the nurse was still filling the syringe and giving the patient the pin cushion treatment. When the doctor was approached about it, "Oh," he said "heavens, are they still giving it? I didn't know. Why that patient hasn't needed penicillin for the last two months."

Now let us look at the reverse of this picture. A patient may have a blood stream infection or a subacute bacterial endocarditis and it may be the doctor's full intent that he is going to keep this patient on a million units of penicillin for thirty days or sixty days. All the Commission asks is that every order be written, have a stopping point, be it a week, a month, or two months, and at the end of the stopping period the nurse will come and say, "Doctor, the order has expired, do you wish it renewed? If so, in what amount and in what periodicity." This stop order has been aimed largely at the antibiotics and the chemotherapeutics, ACTH, cortisone, and what they have referred to as dangerous

drugs. The two dangerous drugs that I run into most frequently are the ergot preparations and the anticoagulants which are used largely with coronary disease. Often the doctor will come to you and say, "This is utterly stupid. We know the potential danger of anticoagulants." There are enough records where anticoagulants have been used too long and there are some doctors who think that they have been used improperly and there have been a few deaths caused by the use of these anticoagulants. All that the Commission asks is that the doctor say how long he wants a drug used.

You may be regulated in certain States and communities on narcotics, hypnotics, and other drugs, where you have no choice on the time; neither does the doctor. In these other areas it is now the Commission asking you if you will please have a stop order put on. They do not identify the drugs. They say expensive and dangerous.

CONSULTATIONS

There is another item that I have been running into recently and that is reaching for the 20 per cent consultation rate which, in some hospitals, seems to be difficult. There are two items which are not generally considered to be consultations, but which you may count as such according to Dr. Kenneth Babcock, in his talk at Chicago during the AHA Convention: Frozen sections, which are done in pathology during surgery, may be considered as consultations, because at this point the surgeon will not determine in his own mind whether he is going to do a simple breast removal or whether he is going to do a complete job taking the glands in the axilla out as well. This counts as a consultation. Cases of x-ray therapy, (not x-ray diagnosis, but x-ray therapy) in which a doctor goes to the radiologist and say, "My patient has a certain type of tumor. In your opinion, is it amenable to x-ray therapy?" may be counted as consultations. These two items will often give you a bit higher consultation percentage.

THE ATTENDANCE REQUIREMENT

A third item which I have found is giving hospitals a great deal of difficulty is the 75 per cent attendance requirement. Often hospitals have come up with a record of 71 per cent or 73 per cent, and it seems such a shame that they lose out on this item. As we do a professional audit we will find that some of the doctors were out of town attending the American College of Surgeons meeting in San Fran-

cisco, or the AMA in Chicago, or, in some instances, two obstetricians were in the delivery room delivering a baby and this pulls the attendance rate down. We have found that there are three legitimate excuses for not attending a meeting, and that, if these excuses are properly presented and accepted, the base upon which the percentage is figured is reduced automatically and the percentage is better. The three legitimate reasons for absence from meetings are illness of the doctor, absence from the community, and attendance at a medical emergency. What I have been suggesting to doctors is that they write two lines to the president of the staff or whatever the committee is that handles this, saying: "Dear Doctor, I regret that I will be out of town on January 5," and sign it. These should be attached to the attendance figures, and when the surveyor comes around and finds them he knows that you have been following the rules.

THE JOINT CONFERENCE COMMITTEE

The next thing that I seem to run into trouble on around the country is the function of the Joint Conference Committee. Many hospitals started a year or two ago to set up a Joint Conference Committee but at the end of a few months it fell of its own weight, and in talking with administrators and doctors I have been told "It didn't work. We met the first time and had a lovely lunch and became acquainted. The second time we met we discussed the World Series. The third time we met we discussed intervention in Egypt. When it came time for the fourth meeting the doctor called me up and said, 'Mr. Administrator, do you have anything on your mind? I don't have anything on mine.' Then I called the representative from the board and said 'Anything on your mind?' and he said 'No,' so we just skipped that one. Then it came to the next month and they called me and said I won't be there and that was the end."

This will always happen unless you have a planned program. We scratched our heads for a long while to try to find a technique which would keep the Joint Conference Committee working well. We made this suggestion and it has worked in a number of hospitals where we have set up a program for accreditation. First of all, the board of trustees is legally and morally responsible for the medical and hospital care that goes on in their institution. It cannot fulfill its legal and moral responsibilities for medical practice for it is not qualified nor able to do it. It must delegate it to the medical

staff. Unfortunately, up to recently, it relegated rather than delegated, and then forgot it.

My suggestion is that once a month the doctors on the staff bring to the Joint Conference Committee a single sheet of paper on which they record their score. Do not mention patients, do not mention specific doctors. This should not concern the board. The staff doctors should say, "Our autopsy rate this month is 18 per cent; accumulated for the year it is 29 per cent; our objective in this hospital is not to let it go below 20 per cent." The same type of statistics should cover other activities. In one five minute session representatives of the board of trustees can know whether this medical staff is anywhere near meeting the objectives. In turn, the lay representatives should bring to their doctors, in the sense of fair play, a sheet giving them information; enough stimulating information so that the doctors will know that you are giving them a report of your stewardship as a lay board and as an administrator. Then you move on from here and discuss subjects of mutual interest.

The key man in this area of mutual interest will always be the administrator. Each of you administrators should put a folder in your desk marked Joint Conference Committee ideas. As ideas develop you drop them into the folder. It is well to keep in mind that your Joint Conference Committee has no power to act; that it must, after discussion, refer back to its two parent bodies (the medical staff and the board of trustees) those things which create action.

We have found, as we have gone around, that where the Joint Conference Committee has worked well, the lay people have said, "Do you know, doctor, for the first time I've really gotten to know our medical staff." Or the doctors have said, "These lay people do a great deal, don't they. They have a lot of problems. We never realized it." It is on the Joint Conference Committee that I think we're going to get the full measure of cooperation that we all desire for quality care.

DIFFERENT GRADES OF APPROVAL

One change in the status of accreditation may be new to some of you although you may have heard it in Chicago, or read of it. In the original days we had three categories: full approval; provisional approval; and no approval. We ran into difficulty in this middle bracket. Many a hospital got this provisional approval when they were in the middle of a fund raising campaign, or it jeopardized their listing for internships and residencies or some other type of thing, and it created a great deal of difficulty. Some one in Chicago came up with the suggestion, "Let's not put this onus on the hospital in the minds of the public. What we're trying to do is say you're on the edge. You're not quite bad enough to disapprove. You're not quite good enough to get full approval. We'd like to put you on warning." So they now have adopted these categories: no approval; approval for one year without certificate; and approval for three years, with certificate. This gives the hospital that has a one year approval, the chance at least to say to its community we have been accredited, and you will be telling the truth. Whether you go on and say its one or three years is your business.

You may have two of these one year approvals. If on the third visit after that you don't make the grade, then you drop to no approval. In other words, you cannot continue endlessly in the status of a one year accreditation.

The American Medical Association is engaged in a campaign to inform physicians of the functions of the Joint Commission on Accreditation of Hospitals. Organized medicine in turn has informed the American Medical Association and the American Hospital Association that the time has come to acquaint hospital boards of trustees and administrators of the value and accomplishments of the Joint Commission. We must all realize that the Joint Commission is a vital factor in helping to emphasize that fact that the care of the patient should be the first consideration in every hospital.

THE SIMPLICITY TO WONDER

The Author. *Professor of Pharmacology, University of Maryland School of Medicine, Baltimore, Maryland*

JOHN C. KRANTZ, JR., *Baltimore, Maryland*

"New experiences teach new duties,
Time makes ancient good uncouth.
He must onward still and upward
Who would keep abreast of truth."

Rudyard Kipling characterized that fine art of critical thinking when he penned:

"I have six faithful, serving men
That serve me till I die,
Their names are who, and what, and when,
And how, and where and why."

My story begins in 1664. Charles II sat on the throne of England. The reign of no other British monarch witnessed such an illustrious galaxy of Englishmen. To philosophy and literature this era gave John Locke and Samuel Pepys, poetry was enriched by the advent of Milton and Dryden, and the names of Isaac Newton and Robert Boyle were inscribed upon the scroll of science. The architect, Christopher Wren, was contemporaneous with this distinguished group. Wren suggested to Boyle that if he could insert a quill into an animal's vein he could inject medicine or poison at will directly into the animal's circulation. Owing to the brilliance and resourcefulness of Wren, who at 24 was appointed Gresham Professor of Geometry at Oxford, Boyle was prompted to try the experiment. A dog was lashed to a table in the warden's dwelling at Wadham College. One of the superficial vessels of the leg was exposed and a quill inserted directly into the vessel and ligatured. By means of a syringe an infusion of opium was injected. With bated breath the two investigators watched the animal slump into a deep narcosis. Inspired by the success of this experiment the architect and chemist transfused blood from one dog to another. A new era in medicine was to be established; the quill became the precursor of the hypodermic needle which has made available as medicinal agents a host of substances which would otherwise be without therapeutic value.

IN MY remarks to you I wish to dwell upon an attitude of mind, one that has made this medical association great, and one that has contributed so much to human progress. It is a sane, a valid, an emotionally mature attitude which I have chosen to call "The Simplicity to Wonder."

When Benjamin Franklin was in England the parliament was composed of three estates, the Lords Common, the Lords Noble and the Lords Temporal. Sir Edmund Burke, pointing to the reporters in the gallery, the gentlemen of the press, referred to these men as the fourth estate, probably destined to play as great a part in the history of mankind as any of the other three. Burke was unmindful of the fact that there was in England in the person of Benjamin Franklin a prototype, an exemplar of the new estate, the fifth estate, men of science, architects of progress who were destined to remold the character of man's life upon this planet.

It is altogether fitting and proper that we should think together about some of these members of the fifth estate who have played an important role in human progress. Few indeed are those in any generation who by their scintillating intellects and indomitable curiosity have broken through the frontiers of scientific knowledge and achieved discovery—discovery, the increment of progress, discovery, the differential coefficient of the curve of knowledge. I know of no better way to characterize these men than to say that "they have the simplicity to wonder, the ability to question, the power to generalize and the capacity to apply."

Lowell expressed the spirit and service of science in these inspiring lines:

Delivered at the Centennial of the Waterbury Medical Association, February 5, 1957

In 1665 the experiments were precipitously interrupted. The plague in London had reached its peak. Wren was off to Paris. The flamboyant Gothic architecture captured the imagination of the sagacious young scientist. Paris was building and Wren was a keen observer. In 1666 London was razed to the ground by the great fire. Hardly had the ashes cooled when Wren returned to aid in rebuilding a new London, and thus this scientist became a distinguished architect. As one stands in St. Paul's Cathedral and reads the timeless epitaph, "If thou seek His monument, look about thee," you can feel the spirit of the genius of Wren, a man with the simplicity to wonder, the man who gave to medicine the art of transfusion, and the concept of the hollow hypodermic needle.

The year is 1790, the scene is Paris. The thunder of the Revolution shakes the earth. Yet in the quiet and calm of his laboratory, Antoine Laurent Lavoisier is putting a great question to nature. He has been told that when substances burn they lose a mysterious material called phlogiston. Lavoisier did not believe it. He asked, "How do you know that?" "If phlogiston exists," said Lavoisier, "I shall get it and weigh it on the balance and compute it by mathematics. If I cannot weigh it or compute it by mathematics it does not exist." And thus with this spirit of wholesome inquiry he showed that burning was not the dephlogistination of matter but a combining with oxygen. "And then what about breathing?" inquired Lavoisier. He described the oxygenation of blood in the lungs and developed the biological chemistry of the pulmonary circulation described by Servetus.

But Lavoisier was an aristocrat and the Revolution rabble was in the saddle. He was snatched abruptly from his experiments and tried before the revolutionary tribunal. Robespierre drew his finger around his neck and declared, "The republic hath no need of savants." On May 2, 1794, third in a line of 28, Lavoisier rode in the tumbril over the cobbled streets of Paris to the Place de la Concorde. The guillotine fell. Lagrange very trenchantly commented, "It took but a minute to sever that head; France will be a century in producing another like it." This statement was prophetic, because France did not produce another citizen like Lavoisier until the advent of Louis Pasteur. With the simplicity to wonder he has been fittingly called the "father of modern chemistry."

The charming widow of Lavoisier escaped the

guillotine. She married Count Rumford, who settled in London and founded the Royal Institution. It was here that Sir Humphrey Davy worked. It was here that Michael Faraday, the bookbinder's boy, came to hear Davy's lectures. In this institution Faraday made benzene, which has molded man's destiny on this planet. Here Faraday broke the lines of magnetic force around a magnet and induced an electric current. On this occasion Gladstone inquired of Faraday, "Suppose you have induced a current into that wire, what of it, Mr. Faraday?" Faraday replied, "Some day you will be able to tax it." Toward the end of a career replete with discovery, someone inquired of Sir Humphrey Davy, "What was your greatest discovery?" Unhesitatingly he replied, "My laboratory boy, Michael Faraday." That spirit of inquiry, the scientific attitude, again had helped to serve the destiny of mankind.

Toward the end of the 18th century one of the most distinguished societies of England was the Lunar Society. Among its members were Erasmus Darwin, grandfather of the immortal Charles Darwin; James Watt, who discovered the power of steam; Joseph Priestly, who discovered oxygen and nitrous oxide; and William Withering, the "flower of English physicians." The principal of Brazen Nose College was seriously ill with dropsy. The standard treatments of the day had failed. The herb concoction of Mrs. Hutton of Shropshire was tried and produced dramatic results. This information reached Withering, who had the simplicity to wonder about it. He sought out Mrs. Hutton and for a few golden sovereigns secured the formula for the herb concoction of many ingredients. Carefully and experimentally on turkeys he tried the activity of the various herbs, ultimately arriving at the conclusion that it was the leaf of the purple foxglove that was responsible for the beneficial results. One can hear him declare, "With this drug we can regulate the pulse at will." Little did he realize the importance of that timeless paper published in 1785, "The Foxglove and an Account of its Medicinal Properties." Withering, the busy clinician; Withering, the connoisseur in mineralogy, would have been lost to posterity, and the same tomb which covers his body would have covered his fame also if he had not had the simplicity to wonder about and the ability to question an old herb concoction.

The year 1929 was a great one for the human race. It was at that time that Alexander Fleming discovered that the presence of the mold peni-

cillin on a dish containing a certain bacteria in a culture media prevented the growth of the organism. It occurred to him that molds might produce a substance inimical to the growth of bacteria. He made extracts of the mold-growth material and injected them into mice infected with pneumonia and other organisms, and he was able to save their lives. Actually that experiment of Alexander Fleming reminds one of those words of Louis Pasteur, "In the field of observation, chance only favors that mind which is prepared." Fleming turned to the medical profession and said, "Gentlemen, I have a drug made from a mold that will be useful in the cure of infectious disease." They turned a deaf ear to him. A decade passed.

It was a foggy, cloudy, damp day in February, 1940 that a British bobby who had cut himself while shaving went to Radcliffe Hospital in Oxford with a staphylococcus aureus septicemia. The whole gamut of sulfonamide drugs was tried but he got progressively worse. In the adjoining room Chain and Florey were repeating the experiment of Alexander Fleming. They injected their penicillin extract into the British bobby and his fever dropped precipitously. He appeared to be getting well but they were out of the drug and the British bobby died. These astute workers saved the urine from the now dead British police officer and extracted from it penicillin. The evidence was overwhelming that these British workers had obtained a drug useful in the treatment of infectious diseases.

Soon penicillin was made by the pharmaceutical manufacturers of this country and placed in the hands of our Armed Forces, and then given to the civilian population. After fifteen years we look back and see that for the first time on this planet man has an anti-infective drug useful against many deadly organisms and which is without any marked toxicity to the human being. It was the simplicity to wonder which brought us this great medical discovery.

It seems unnecessary to extenuate the matter. That superb quality of mind, the simplicity to wonder, has endowed man with infinite blessings and has been the motivating force in human progress.

But now we have come to a place in our pilgrim-

age which reminds one of Lewis Carroll's remarks in *Alice in Wonderland*. The Fairy Queen, speaking to Alice, said:

"Now here, you see, it takes all the running you can do to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that."

Man is at the crossroads since the release of atomic energy at Hiroshima. Its impact upon life on this planet will vie in geology with the crack of the glacial ice, in the biological development of man with the day when he discovered for the first time fire to warm the body, or the invention of the wheel to carry his burdens over the surface of the earth. All of the hopes, all of the yearnings, all of the struggle, all of the study and toil through the ever lengthening past, has brought us to a place where self destruction en masse is possible and perhaps imminent. Shall we then as scientists not examine ourselves and ask what is the purpose of it all? Do we labor

To come up with some new mere differential equation,

Yes as a means but not an end,

To discover some new chromosomal relation in violet,

Yes as a means but not an end.

To invent some new gadget to carry us ten times faster than sound, so that we have more motion and still less sense of direction,

Yes as a means but not an end.

We must at last as scientists be convinced that the ultimate reality is mind; without it the material world is purposeless and the spiritual world unattainable. It behooves us, therefore, to set our sights higher. As St. Paul expressed it, "Set your affection on things above." For what we are seeking as ultimate ends are Truth, Beauty, Goodness and those qualities of the mind. They alone bring peace of mind to men.

Go with me if you will to Sacramento, California. We are approaching one of the massive capital buildings. As we enter that door a caption above it catches our eye, "Give me men to match these mountains." What this old world of ours so desperately needs are men and women with the eternal goodness of the Golden Rule in their hearts to match the scientific greatness of this great hour, the hour which marks the dawn of the second century of the Waterbury Medical Association.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Is Mitral Stenosis Always a Surgical Condition?

Few developments in medicine have had an impact upon both doctors and laymen as dramatic as that of cardiac surgery. It is not surprising that widespread interest and enthusiasm should have been aroused by the vision and imagination of the pioneers in this new field, followed so rapidly by courageous action. Surely there have been few advances in any clinical field which could compare with this in its rapid conquest of one after another of the conditions regarded as unconquerable only a short time ago. To many of us it seems only yesterday that successful closure of the ductus arteriosus was accomplished, to be followed shortly by the Blalock-Taussig operation which has transformed the lives of thousands of unfortunate children. And then, in almost bewildering succession, we have witnessed the development of operations for the correction of several kinds of rheumatic valvular disease and many congenital malformations, culminating in the spectacular achievements of open-heart surgery. Coincident with this breath-taking progress in cardiac surgery there has been an advance in vascular surgery which would have seemed miraculous had it not been overshadowed by the almost incredible operations within the heart. Who among us would have been so bold as to predict even a few years ago that the operative mortality in successful mitral valvulotomy would be of the order of one per cent or less?

The earliest successful intracardiac operation was

that for the correction of mitral stenosis. It is probable that this is still the one performed most frequently throughout the world. Many thousands of patients have been restored to normal or almost normal activity, and thousands of others greatly benefitted, by this relatively simple procedure. It is almost inevitable that many doctors tend to think first and only of surgical operation when they encounter patients who have mitral stenosis. But to do this is to ignore the physiology and pathology of the underlying rheumatic heart disease, which may be more important than the mechanical narrowing of the mitral orifice. It detracts nothing from the brilliant achievements of the surgeons to remind physicians that rheumatic heart disease still has medical aspects that cannot be ignored safely, even in those who are subjected to operation. Many of these important medical aspects are discussed with clarity and authority in an admirable paper in this issue of the JOURNAL.

Connecticut and Medical Education

Public apathy toward limitation of opportunities for Connecticut youth to obtain medical and dental education continues. SB9 that would have provided an appropriation of \$500,000 to the Board of Trustees of the University of Connecticut to prepare and obtain plans and specifications for the construction of a medical-dental school and to purchase land in the name of the State for such purpose got hopelessly bogged down in the Appropriations Committee and was not reported out. This

might be understandable because an additional half-million dollar appropriation by the 1957 General Assembly could have thrown things badly off balance though an appropriation was made for a school of veterinary medicine.

Another proposal that would have required far less money and might well be in the nature of a valuable experimental inquiry as to the actual need for a second medical school in Connecticut was turned down. This would have been participation in the New England Board of Higher Education Plan for increasing the number of New England students in the medical schools in the region.

The plan is, and it is reported that the six New England medical schools and two dental schools have agreed to take part in it: For States to utilize public money in the amount of \$2,500 per student to subsidize medical education and \$1,500 per student for dental education in New England schools for each student from the State enrolled in excess over the number enrolled on October 1, 1956. Two States, Maine and Vermont, through legislative action have already adopted the plan and it was under consideration in New Hampshire and Massachusetts. Connecticut took no action on the proposal. This could have been a start to measure the demand and to increase enrollment of Connecticut students in the professional schools in New England. Similar methods of financing are employed in other states of the United States, it helps the schools to meet the cost of operation, but also because of it the possibility of students from New England enrolling in those regions is lessened.

The Problem of Accidental Poisoning

Many American homes today contain a stock of poisons which would delight the perverted minds of the professional poisoners of old. These toxic agents find their way into the home in a very innocent manner in the form of "harmless" medicaments and household agents and chemicals. These latter, which include cleaning agents, cosmetics, deodorants, pesticides, fungicides, rodenticides, detergents and bleaches, and which are all considered essential to every home, contain many economic poisons in the nature of higher alcohols, petroleum products, and toxic heavy metals.

There are approximately 250,000 of these household agents on the American market today, and each can be purchased freely and easily in any supermar-

ket or drugstore. It has been noted that one new such product is introduced daily on the American scene. In most cases the user is completely unaware of the potentially hazardous nature of these substances which through misuse can become killers.

Annually the number of individuals treated for accidental ingestion of medicaments and economic poisons reaches in the thousands. Aspirin, which recently has been described as "by far the cheapest drug on earth and one of the safest," is becoming an increasing hazard to children. At the spring meeting of the American Academy of Pediatrics it was remarked that at least 100,000 children are treated annually for aspirin poisoning. Most often it is the preschool child who is involved, and many deaths have been tabulated for this age group following the accidental ingestion of some drug or household product.

The increasing morbidity and mortality among our children primarily due to these agents is becoming more and more apparent, and is truly cause for alarm. It is difficult to rationalize how a seemingly enlightened, intelligent and home-loving nation can allow such a situation to exist; but it is we adults who compound the slaughter of the innocents.

This is accomplished in many ways; but the blame is chiefly in the easy availability through over-the-counter purchases of potentially hazardous medicaments and household agents which are usually poorly or inadequately labeled and packaged; in the cunning and competitive manner in which these products are advertised and merchandised; and most important of all, in the negligence, ignorance and carelessness of almost every adult which permits these hazardous materials to lie about within easy reach of the exploring hands of some innocent "toddler."

The tremendous success enjoyed by the sale of "candy aspirin" has prompted drug companies to prepare and merchandise other drugs in this "pleasing" but dangerous form. But this method of appealing to children is not the only means used to promote the sale of drugs. Recently there has appeared a clown-shaped medicine bottle specifically designed to attract the child to the container.

We are all aware of the careless and haphazard manner in which household agents are permitted to accumulate on shelves, beneath sinks, in cabinets and other open places. We seem to condone the practice of allowing dangerous medicinals to lie about—and in quantity—on night tables and bureaus,

and in overflowing medicine cabinets and handbags. Further than this, we practice thrift by saving and storing unused paints, solvents and insecticides in drinking glasses, medicine bottles, jelly jars and other convenient receptacles. No one can deny that "accidental poisonings occur in direct proportion to the degree of accessibility of the toxic substance."

The problem of accidental poisoning is real and challenging; but an important advance can be made toward its solution. This lies in the establishment of Poison Control Centers.

The business of establishing a Poison Control Center should not be entered into lightly. It entails a great deal of patience, time, intelligent organization and dedication to an ideal. Those who have been engaged in this endeavor can readily attest to this.

To function efficiently a Poison Center must be prepared to offer the following four services:

1. Emergency treatment for poison cases brought to the Center.
2. Consultive services on a 24 hour basis in matters pertaining to accidental poisoning.
3. Laboratory facilities for emergency toxicology.
4. A program of public education within the Center's operating area.

The first three services are concerned with the immediate and follow-up care of the patient and are geared primarily for the physician confronted with a case of poisoning. These services are certainly very important; but they are superseded in importance only by the fourth service which is concerned with public education. It is only by alerting and advising the public that accidental poisoning can be prevented. Medical agencies working together with service clubs, women's clubs, parent-teacher associations, hospital administrators, health agencies and other civic groups can do much to supply the community with the necessary facts concerning this problem.

This undertaking will, at times, appear discouraging because the problem will be with us always. But with the sharing of responsibility by medical and nonmedical groups alike many good results must accrue, and any benefits, no matter how small, will be a source of satisfaction to all who lend a helping hand.

Crash Injuries

A report on the work of the Cornell Automotive Crash Injury Research Project for the year ending

March 31, 1957 brings out interesting information. Physicians of Connecticut should take a particular interest in these findings since this State is one of twelve, plus the City of Minneapolis, where studies have been carried out. Only two New England States have contributed to the study, Vermont and Connecticut.

The research studies were divided into two groups, the first concerned with all model-year cars, the second, with post-1955 models or components appearing in them. In the former group a study of 1,000 injury-producing automobile accidents disclosed head injuries as the most frequent. Multiple injury was very common, consisting usually of head injury, combined with injury to another body area. It was found also that dangerous or fatal injuries observed in accidents where the traveling speed was less than 60 mph are influenced far more by the design characteristics of objects which the occupant may contact than by the speed at which the cars were traveling before the accident. On the other hand, those injuries where the speeds were above 60 mph are closely associated with speed plus design characteristics and possibly other accident-injury variables such as type of accident, area of impact, etc.

In the post-1955 models there were found to be fewer front-door openings, nearly 50 per cent fewer ejections through popped open doors, and nearly 30 per cent fewer dangerous or fatal grade injuries. Seat belts apparently contributed very definitely to increased protection in case of accident.

The director of the Cornell Research group has issued a warning against reliance on safety belts which are marketed primarily for their cheapness rather than their true protective quality. Some belts were found to break or slip at forces as low as 800 pounds. This situation calls for a real program of education of the public.

Much remains to be done in the Cornell Research study. As a help to the medical profession in developing a more integrated approach to the treatment of trauma observed in accidents, a clearer picture of injury patterns and the most common combination of injuries must be defined. With the approaching 1958 season, the continuing emphasis on speed which has developed in recent years and the increasing automobile output, safety in car design and equipment assumes added importance to the medical profession as well as to each individual automobile operator.

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1832	William Buel, Litchfield	1887	Francis Bacon, New Haven
1834	Thomas Miner, Middletown	1888	George L. Porter, Bridgeport
1837	Silas Fuller, Hartford	1889	Orlando Brown, Washington
1841	Elijah Middlebrook, Trumbull	1890	Melancthon Storrs, Hartford
1843	Luther Ticknor, Salisbury	1891	Charles A. Lindsley, New Haven
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1851	Rufus Blakeman, Greenfield	1894	Francis N. Braman, New London
1853	Richard Warner, Cromwell	1895	Seth Hill, Stepney
1854	William H. Cogswell, Plainfield	1896	Rienzi Robinson, Danielson
1856	Benjamin H. Catlin, Meriden	1897	Ralph S. Goodwin, Thomaston
1858	Ashbel Woodward, Franklin	1898	Henry P. Stearns, Hartford
1861	Josiah G. Beckwith, Litchfield	1899	Charles S. Rodman, Waterbury
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1868	Samuel B. Beresford, Hartford	1904	William H. Carmalt, New Haven
1869	Henry Bronson, New Haven	1905	Edward H. Welch (Resigned), West Win-
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- 1955 Oliver L. Stringfield, Stamford
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To Connecticut Nurses' Association

The President-elect

Meetings Held in August

- August 6—Committee on School Health
 August 7—Section on Dermatology
 August 8—Committee on Third Party Payments
 August 12—Cancer Coordinating Committee
 August 26—Conference Committee with the Con-
 necticut State Bar Association

Special Article

MAJOR ISSUES IN THE PROPOSED COVERAGE OF PHYSICIANS UNDER SOCIAL SECURITY

BENJAMIN B. KENDRICK, *New York, N. Y.*

The Author. *Benjamin B. Kendrick, of New York, New York. Research Associate, Life Insurance Association of America; formerly Social Security Analyst, United States Chamber of Commerce, and Editor, American Economic Security; formerly, Chief of Program Coordination, Social Security Board, Bureau of Old Age and Survivors Insurance*

IMPORTANCE OF ISSUE

This coverage question is quite an important one. If physicians should be brought under the old-age and survivors insurance provisions of the social security legislation—the so-called OASI system—a beginning doctor could anticipate paying social security taxes of up to about \$10,000 in the course of a lifetime of practice—and this figure is based on the unlikely assumption that the OASI system will not be further liberalized during his lifetime. When possible liberalizations in the system are taken into account, the physician's lifetime taxes might run a great deal higher. Roughly offsetting these taxes, of course, are the social security benefit expectancies he would gain.

More important than the dollars and cents of it may be some other questions involved. For instance, would the medical profession be able to speak more effectively in Washington on matters relating to social security, if inside or outside the OASI system? Again, is there any right or wrong to the coverage proposal from a standpoint of principle?

Because of the importance of the issues, it is good that the medical profession is devoting increasing attention to the proposal for social security coverage. Let me say, too, that if doctors should decide to seek OASI coverage, they had better be very sure they have reached the right decision—because once under the OASI system, it is most unlikely they would ever have a chance to withdraw.

THE PHYSICIANS MUST DECIDE

It is of course the responsibility of Congress, in its wisdom, to enact and amend the Federal social security laws. However, Congress has never yet extended OASI coverage to any considerable group of people without evidence that the members of the group preponderantly wanted to be under OASI. If spokesmen for the medical profession should tell Congress that doctors want OASI coverage, they would surely acquire it shortly thereafter. Conversely, if medical spokesmen continue to tell Congress that doctors do not want OASI coverage, then I have no doubt that physicians can remain outside the system—at least for some time to come.

Thus, it seems to me, doctors must decide for themselves whether they want to be in or out of OASI. It would certainly be presumptuous of me—or of any other layman—to try to tell the members of the medical profession what they ought to do. What I may be able to contribute tonight is to furnish some relevant information, and some informed guesses, that may assist those present in arriving at their own conclusions.

VOLUNTARY OASI COVERAGE FOR PHYSICIANS UNLIKELY

In advance of this meeting, Mr. Farrell thoughtfully sent me a copy of the May 1955 report on the Rhode Island Medical Society's membership poll as to physician participation in the OASI system. As you know, the report showed that, while the vast majority of the members responding were opposed to compulsory OASI coverage, voluntary coverage for those wishing it was favored by a good majority.

However, there are a number of objections to voluntary OASI coverage for doctors—or for any other group—and I think Congress is well aware of them. The chief argument against voluntary cover-

An address delivered at the 110th Annual Meeting of the Providence Medical Association, at Providence, Rhode Island, January 7, 1957

Reprinted from Rhode Island Medical Journal, March, 1957

age concerns the so-called adverse selection involved. In other words, the thought is that those whose prospective benefits stood to be greater than their prospective taxes would tend to choose to be in the system, whereas those whose taxes stood to exceed their benefits would tend to stay out. To the extent these tendencies operated, the voluntary participants would make a profit on their coverage. Moreover, assuming the system continues to be run on a self-supporting basis, any profit made by voluntary participants must necessarily be at the long-run expense of the others under OASI, who are almost all covered on a compulsory basis.

Another objection to voluntary coverage relates to what most people agree on as being the system's fundamental purpose—that of furnishing a basic floor of protection for all against want. The argument runs that, under voluntary provisions, those most likely to need the benefits would be the least likely to elect coverage, whereas those least likely to be in need would be the most likely to elect coverage. Perhaps this argument is not entirely applicable to physicians, but certainly there is at least some merit in it.

A third argument is that a governmental program like OASI, dealing with tens of millions of people over scores of years, must be kept relatively simple if it is not to bog down through administrative complexities and costs in sheer bureaucratic weight. And voluntary provisions do mean a great deal of extra complexity that I perhaps need not take the time to spell out.

For these reasons, it seems unlikely that Congress would offer physicians, on an individual basis, the right to accept or reject OASI coverage. I think the actual choice will prove to be between no coverage for any and compulsory coverage for all.

EMPLOYED PHYSICIANS ALREADY COVERED

In saying "no coverage for any," I am of course referring to self-employed physicians. Doctors employed on a salary, as no doubt you know, are now covered by OASI (and have been since the system's inception), if the employment area itself is inside the system's purview.

Perhaps you are not aware of the extent to which physicians already have OASI coverage. I have some figures on this, based on a sample survey made by the OASI Bureau of the Social Security Administration in 1955.

According to that survey, 45 per cent of the 201,000 physicians listed in the AMA directory

had at least some credited earnings under OASI. And 22 per cent of the physicians listed had enough OASI coverage to have a so-called fully insured status under the system or to have had such a status at some previous time.

The sample survey also studied separately the listed physicians who were in self employment (presumably private practice in most cases) at the time the survey was made. Such physicians, of course, could have acquired OASI wage credits either before entering private practice or by part-time employment while in private practice. At any rate, of the self-employed physicians, 35 per cent had at least some covered earnings, while 11 per cent had or had had a fully insured status.

These figures have probably gone up somewhat since the survey was made. The main reason for thinking so is that there have been several bits of new legislation since then, extending the area of OASI coverage, and hence increasing the proportion of salaried physicians who are covered.

In this regard, let me call your attention to some new legislation extending regular OASI coverage, beginning January 1, 1957, to members of the armed forces. There are also gratuitous OASI wage credits provided for military service between September 15, 1940, and December 31, 1956. Both sets of provisions are fully applicable to service in the uniformed forces in any medical capacity.

I know personally of one case where these provisions have already proven effective. There is a lady employed in our office whose husband had been a physician before his death about two years ago. He had never been under the regular OASI provisions, had never paid a cent in social security taxes, and in fact did not even have a social security number. However, he had served for about four years in the armed forces during the war. As a result, his widow and four children together have been drawing \$66.40 a month in OASI benefits.

The general point I am trying to make is that physicians have a surprisingly large amount of OASI coverage already. The proposal we are discussing can hence be restated as being whether doctors wish OASI coverage for private practice to go with the coverage they already have in salaried employment and during periods of military service.

HOW WOULD DOCTORS MAKE OUT COMPARED WITH OTHERS UNDER OASI?

Let me now turn to the question of whether doctors would get their money's worth out of the

OASI system if they were covered under it. This question can best be handled as two separate questions: First, how would doctors make out compared with the general population under OASI? And second, how does the covered population, on an average, make out under OASI? These questions, let me emphasize, relate to compulsory coverage; I have already suggested that physicians would stand to get a good deal more than their money's worth out of the system if they were to have coverage on an optional basis.

No mathematical answer is possible to either of the two questions on compulsory coverage. This is mainly because OASI does not stand still; no one really knows what the system will come to be like in the future. However, I think the questions on how doctors would make out can be answered fairly well—but in non-mathematical terms.

Compared with other people compulsorily covered by OASI, doctors would be better off in one major way, and worse off in another. Doctors would be better off than most others in that, as self-employed persons, they would pay only three-quarters of the combined employer-employee taxes applying to people in covered employment. At the ultimate tax rates, applicable in 1975 and thereafter under the present tax rate schedule, the self employed will pay $6\frac{3}{8}$ per cent in contrast with a combined $8\frac{1}{2}$ per cent on employment earnings.

On the other hand, the OASI benefit formula is geared to favor those at the low end of the earnings' scale. Because physicians tend to be near the high end of the scale, this means that the benefit formula is geared to their disadvantage. But the 25 per cent discount that doctors would get on their tax bill may roughly cancel the fact that the benefit formula would be loaded against them.

There are various other minor points about how physicians would fare under OASI, compared with others under the system, of which perhaps only one is worth mentioning. I have frequently heard it argued that doctors would lose out because they do not normally retire at age sixty-five but continue their practices indefinitely. Hence, it is argued, physicians could not draw OASI retirement benefits because the so-called work clause would operate to prevent it.

In my best judgment there is little real substance to this argument. For one thing, most laymen likewise do not retire at age sixty-five. The statistics show that, so far, the average age at retirement under OASI has been about sixty-nine. Moreover,

there is a provision in the OASI legislation that the so-called work clause ceases to apply at age seventy-two. And it is not at all far fetched to think that Congress may reduce this age at which benefits become payable regardless of earnings to seventy.

So, all things considered, I think doctors would make out about as well under compulsory OASI coverage as do people generally.

HOW DO PEOPLE GENERALLY MAKE OUT UNDER OASI?

But does the covered population generally get its money's worth from OASI? On the whole, I think so—but I am speaking now only about the existing system, and not about what it may come to be in the future.

In any event, the aggregate of benefit payments under the system does not differ greatly from the aggregate of tax receipts. Some of the past tax receipts have been used to build up a relatively small reserve fund, which is still increasing slowly. This fund earns interest, which adds to the amounts available for benefits. On the other hand, administrative expenses are paid out of the fund. Concerning administrative expenses, I may say that the OASI program is a huge, mass-production type of operation, and as a result the administrative costs run only about 2 per cent of the sums taken in or paid out.

In contrast to an insurance company, OASI pays no taxes and employs no salesmen. On the other hand, the interest earnings of OASI are quite small, relatively speaking. This is mainly because the system has operated on nearly a pay-as-you-go basis, and consequently the reserve fund represents only a small fraction of the accrued liabilities. Also, the funds are invested in Government bonds, which bear a relatively low interest rate.

Of course, there is much more to it than these brief comments indicate. An insurance company guarantees its policy benefits; OASI benefits, on the other hand, are subject to change—or even discontinuance—at the will of Congress, as Section 1104 of the amended Social Security Act explicitly provides. Also, loans can be had against insurance-policy reserves; in OASI there are no loan provisions.

More important, insurance companies offer numerous policies from which the purchaser can carefully select the one best meeting his needs, desires, and premium-paying ability. In OASI, by contrast, there is no choice: One set of benefit and tax provisions applies, willy-nilly, to all.

Perhaps this last point is the heart of the matter. As a social benefit program, designed to meet the minimum needs for protection of the population generally, OASI can be considered a good buy, with the participants, on the whole, truly getting their money's worth. However, if OASI should be over-expanded, and attempt to provide full protection for the population, then participants will no longer be getting their money's worth because their taxes will be buying benefits differing, more or less, from what they need, want, and are willing to pay for. And no misfit article, that you are required to use, can be a good buy regardless of the price.

QUESTIONS OF PRINCIPLE AND PHILOSOPHY

More important than the dollars and cents of doctors' coverage under OASI may be questions of principle or philosophy, as I suggested earlier. The trouble is that some people—using one line of argument—arrive at the conclusion physicians certainly should be covered, while others—using another line of argument—conclude that they certainly should not be.

People such as some of my former colleagues at the Social Security Board argue that OASI is designed to furnish universal protection, that the system cannot work with maximum efficiency so long as any important group remains outside it, and that consequently physicians should be brought under the general law. My own feeling is that, while there is some validity to this argument, universal coverage is not really essential. Also, I think it is proper—and in accord with democratic principles—for Congress to take the wishes of the group affected into account.

The opposing view, briefly, is that social security is a step on the road to socialism and worse—and that the medical profession should consequently oppose coverage with vigor. My own feeling is that, while future history might verify the first part of this argument, the second part does not follow. In other words, if broad forces are leading the United States to socialism, the trend could hardly be affected much by the action of physicians on OASI coverage.

All in all, I am personally not convinced that there are over-riding considerations of philosophy or principle either way. Consequently, if I were a physician, I think I would view the question mainly from an economic standpoint, making the best guess I could as to what changes in OASI the future is likely to bring.

FUTURE CHANGES IN OASI

And that leads us to the \$64 billion question—how will OASI be shaped in the future? Will the system be over-expanded?

It could happen. Surely Congress will be subject to continual pressure for OASI liberalization—higher benefits, more lenient eligibility requirements, new types of benefits. And it can scarcely be doubted that some liberalizations will be enacted from time to time.

Nevertheless, I am cautiously optimistic that the pressure for continual OASI expansion can be contained fairly well within reasonable bounds. The chief thing that makes me think so is the growing evidence that the repeatedly increased OASI payroll taxes are beginning to become high enough and painful enough to encourage voters to carefully scrutinize all proposals to expand benefits.

During consideration of the bill which became the 1956 Social Security Amendments, Congressmen seemed very conscious of the tax angle. The original bill had provided full benefits for women at age sixty-two, instead of sixty-five, but this provision in conjunction with the new cash disability benefit provisions would have cost employers and employees a tax increase of one per cent of payroll. To avoid such a tax increase, reduced benefits for wives and working women below sixty-five were substituted, with the tax increase being held to one half of one per cent.

Moreover, it is important to remember that existing law provides a whole schedule of tax increases to take effect between now and 1975. And these tax increases, of course, are required merely to meet the growing costs of the present benefit provisions—they cannot be used to provide additional benefits. When the American people have had to meet the first one or two of these scheduled tax increases, with no corresponding increase in benefits, they will be even less willing than at present to pay still higher taxes for new liberalizations in the benefit provisions.

POSSIBLE OASI LIBERALIZATIONS AFFECTING MEDICAL PRACTICE

What possible liberalizations in OASI would affect the practice of medicine? Let me devote just a minute or two to this question.

To begin with, as you know, the new cash disability benefit provisions in the 1956 Amendments do affect medical practice. The doctor's role is to make examinations and certifications as to appar-

ently disabling impairments, subject to some supervision from the social security authorities.

There will surely be intense pressure for expansion of these new provisions. Under present legislation, the benefits are available only at age fifty and over, but demands are already heard that they be provided regardless of age.

Moreover, there are no benefits for the wives and children of disability beneficiaries under the new provisions, whereas dependents' benefits are provided under OASI in case of retirement or death. Dependents' benefits in disability cases are sure to be urged.

Also, the 1956 Amendments provide benefits for disabled children. You see there are two separate things: benefits for the able-bodied dependents of disabled people, and benefits for the disabled dependents of people who are dead or retired, but not disabled. In any event, the new principle of benefits for disabled dependents could conceivably be carried much further.

Now as to the possibilities for Federal medical care benefits—that is, socialized medicine—either inside or outside the OASI system. It seems clear that the direct threat of such legislation has largely evaporated. And I think much of the credit is due to the phenomenal growth of voluntary health insurance—both in numbers covered and in the breadth and depth of their protection. Here I think the insurance companies—along with Blue Cross and Blue Shield—are entitled to a bow.

The Achilles heel in the body of voluntary health insurance may be in the limited extent to which the retired aged are protected. There seem to be growing demands that OASI be expanded to include medical-care benefits for old age beneficiaries. Incidentally, this proposal is not new; you may recall that Oscar Ewing was urging the same general plan when he was Federal Security Administrator.

If the past is any guide, it seems likely that voluntary health insurance will solve the problem of providing more adequate protection for the retired aged. In particular, there are encouraging new developments in adding group health insurance protection for retired employees to employer and union welfare programs.

However, voluntary health insurance cannot do the entire job over night. The new policies mainly give protection in retirement to employees now active. For a temporary period, there will continue

to be a partial vacancy—enticing to the proponents of compulsory health insurance. If their noses should enter the tent, a general socialized medicine program might follow.

COULD MEDICINE SPEAK BEST INSIDE OR OUTSIDE OF OASI?

This foreboding possibility leads to a question I raised at the outset—would the medical profession be able to speak more effectively in Washington on social security matters, if inside or outside the OASI system? As I see it, there are three answers to this question, depending on the type of matter being considered.

If the issue is one affecting the practice of medicine, such as a proposal to add more disability benefits or some medical-care benefits to OASI, then doctors are qualified to testify as experts. On such an issue I think it would make little, if any difference whether the doctors were themselves covered by the system.

If the issue is a general social security one, not affecting the practice of medicine, then it seems to me doctors would have little reason to testify, and little weight if they did, unless they were themselves covered by OASI. I can imagine a Congressman thinking: "What business is it of the doctors to concern themselves with a proposed increase in social security taxes and benefits, if they are themselves outside the system?"

The third kind of issue I have in mind is the sort posed by the so-called Jenkins-Keogh bill. This proposal is one to give favorable income tax treatment to sums set aside for their retirement by doctors and by other self-employed people. Here I can imagine a Congressman asking: "Why should we give doctors this special tax treatment, when they are unwilling to come under the general retirement system Congress has set up?"

CONCLUSION

In conclusion, I must confess it all adds up to nearly nothing—in other words, that the cons just about balance the pros. Perhaps, as I see it, there is a bit more to be said in favor of OASI coverage for doctors than against it. However, the difference is not great. And, depending on the relative importance one attaches to the various points, he could easily reach the opposite conclusion.

Gentlemen, it is your decision. It is your views which will decide the question, not mine.

ON THE DECISIONS OF THE PROFESSIONAL POLICY COMMITTEE REGARDING PROFESSIONAL SERVICES OUTSIDE OF GENERAL HOSPITALS

THE Professional Policy Committee of physicians of Connecticut Medical Service, Inc. at its meetings on April 8, 1957 and June 25, 1957 established certain professional policies for the processing of claims covering the treatment of superficial and skin lesions to be effective on June 1, 1957 and August 1, 1957, respectively.

These policy decisions have apparently been misunderstood and misinterpreted by some physicians as evidenced by telephone calls and correspondence to the General Offices. The Professional Policy Committee at its meeting on July 29, 1957 suggested that a summary of the situation be prepared for publication in the JOURNAL to clarify the CMS position on the points which have been raised regarding the policy decisions.

WHY WAS IT NECESSARY THAT THE NEW POLICY DECISIONS BE ESTABLISHED?

After an extended study for fifteen months of the constant increase in the rate of utilization for the services provided by the CMS contracts, which reached a degree that actually made the membership charges inadequate for the continued provision of the benefits, the Professional Policy Committee approved the recommendation of the Administration that only by restriction of CMS benefits to those for which CMS is legally liable under its contracts, and the strictest application of the contractual provision that no benefits should be available for services which do not, or which are not intended to, improve physiological function, could the Preferred Contract continue to be adequately underwritten on the present structure of membership charges. The Board of Directors adopted the recommendation of the Professional Policy Committee and requested that the Committee continue its efforts to provide CMS benefits only in strict compliance with its contractual liability to CMS members. The Board pointed out that while it has always approved suggested liberalizations of the contractual liabilities of CMS when surplus funds were available to provide them, it could not approve the continuance of extra contractual benefits unless warranted by the financial situation.

WHAT IS THE AUTHORITY FOR THE POLICIES ESTABLISHED?

The contract between Connecticut Medical Service and its members states specifically in Article XIII, 1, a, that CMS shall have ". . . due proof satisfactory to itself . . ." that the procedure has been rendered before making payment of any claim. Since differential fees are provided for several types of lesions, such as tumors, depending upon their pathological structure, it is incumbent upon the Corporation to determine whether a tumor, for instance, is benign or malignant, or in fact a tumor, in order that proper payment may be made.

The Professional Policy Committee, under the By-Laws of this Corporation, Article VII, Section 3, is empowered, subject to the right of the Board of Directors to exercise final authority, to determine "a. All questions involving . . . professional practice." It is clear, therefore, that the Professional Policy Committee is well within its authority in requiring pathological reports on tissue removed by surgical operation when, in its opinion, such reports are necessary to provide proof satisfactory to itself of the nature of the surgical procedure. In addition, the contract specifically states that in all cases where no fee is specified for a procedure listed in the Schedule of Surgical Operations, Section XI of the member's contract that:

"Note a: Payment will be made in all cases on the basis of decisions made by the Professional Policy Committee of physicians. The amount of payment will be determined by the extent of the procedure, in its proper relation to the fixed items in the Schedule of Surgical Operations. All such decisions will be final."

Another consideration as to the necessity for the receiving of pathological reports at the discretion of the Professional Policy Committee is that no claim may be paid under the terms of the CMS contracts, Article VIII, paragraph 1, d, "With respect to surgical operations performed solely for cosmetic purposes or which were not devised to, or which do not, improve physiological function."

DOES THE REQUIREMENT OF A PATHOLOGICAL REPORT
SUBJECT THE PATIENT TO ADDITIONAL EXPENSE?

In all probability it does. This fact does not in any way, however, violate the contract between the Subscriber and this Corporation. The member is entitled to all benefits of the CMS contracts and, conversely, the member is not entitled to any benefits which are not provided by the CMS contracts. The Corporation has contracted in good faith with the Subscriber to provide certain services; it has always done so, and will continue to do so. The Corporation, however, is not liable to make payment for professional services rendered a patient which are specifically excluded as benefits in the contract with the Subscriber.

WILL THESE POLICIES TEND TO INCREASE UTILIZATION
OF HOSPITAL SERVICES?

There is no reason why the incidence of hospitalization should be increased. The decisions in no way deprive the member of his usual coverage for the treatment of superficial and skin lesions when such treatment is necessary. It is doubtful if any expense incurred in payment for a pathological report is any greater than would be incurred if the member were hospitalized and paid the expenses not covered by hospitalization insurance. In any event, the question is not pertinent to the discussion of professional policies involved in the decisions in question.

DO THE DECISIONS INFRINGE ON THE RIGHTS OF
PRACTICING PHYSICIANS?

The specific question raised by some physicians was that the requirement of a pathological examination of excised tissue was an infringement upon their rights to decide whether a pathological examination of excised tissue was necessary. The answer to the question is a very definite no. The policies on professional services performed outside of a hospital effective August 1, 1957 do not, and are not intended to, infringe on the right of any practicing physician to decide whether or not he wishes to have a pathological examination made of tissue which he removes surgically. The question in point is, not whether the physician feels that a pathological examination of surgical removal of tissue is or is not necessary, but whether the patient is entitled to reimbursement under the Regulations of the CMS contracts of the cost of the surgical procedure which was performed. All tissue removed in hospital operating rooms is submitted for pathological examination; it was felt that similar pathological

examinations should be required on tissue removed surgically outside of general hospitals.

A STATEMENT BY THE PROFESSIONAL POLICY
COMMITTEE

At its meeting on July 29, 1957 the Professional Policy Committee reviewed the correspondence received from physicians and there was an extended discussion of all aspects of the situation following which the Committee reaffirmed the policies under discussion and clearly delineated the fact "that these policies do not, and are not intended to, restrict, direct, or interfere with the practice of medicine by physicians."

AMA Announces Two Changes in Administrative Setup

The American Medical Association has announced two important changes in its administrative setup. The Board of Trustees elevated Dr. George F. Lull of Chicago, who has been secretary-general manager of the Association for 11 years, to the newly created position of assistant to the president of the AMA. He will continue serving as secretary, which is an elective office.

At the same time, the Board announced the appointment of Dr. F. J. L. Blasingame of Wharton, Texas, to the position of general manager of the American Medical Association. He will take over his new duties on January 1, 1958.

Dr. Blasingame, who is 50, has been active in medical affairs, both at the state and national level, for many years. When the AMA House of Delegates elected him as a member of the Board of Trustees in 1949 he was one of the youngest physicians ever chosen. Since then, he has held many important AMA committee appointments.

He served as president of the Texas State Medical Association in 1955.

In his new job, Dr. Lull will relieve the president of the Association of many of the burdens of this office, which have become especially heavy in the last few years. He will serve as spokesman, troubleshooter, listening post, information center and as an ambassador of the medical profession in cities and towns throughout the country. His experience is invaluable, and it will be applied in solving medical problems at the state and local level, as well as nationally.

WORLD MEDICAL ASSOCIATION

CONNECTICUT COMMITTEE

Stanley B. Weld, *Chairman*, Hartford

John H. Foster, Waterbury
Amos E. Friend, Manchester
Alfred Labensky, New London
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Walter Weissenborn, Hartford

THE NECESSITY AND IMPORTANCE OF THE WORLD MEDICAL ASSOCIATION

SINCE more and more problems, including those pertaining to medicine, are being discussed and implemented at the international level, were there not already a World Medical Association one would certainly have to be organized.

There are some 1,600 international organizations large and small. Many of these are medical in nature and there are others of a nonmedical nature that intrude into the medical field. A number of the medical organizations are solely scientific in character and exist only for interchange of scientific information and fellowship. They do not enter into the socio-economic phases of medicine. The contrary is true of others and this is particularly the case with the nonmedical group.

It would seem that doctors should know better than anyone else how to practice medicine and of what good medical care consists. There are, however, several lay dominated organizations which not only endeavor to prescribe general rules for the practice of medicine, but try to dictate how the doctor should actually treat his patient. Not only do they do this but they completely ignore the medical profession in the procedure. By "ignore," I mean not only do they not follow their advice, but usually do not even ask for it.

Governments, social security bodies (which are usually government agencies), and certain international organizations, governmental and nongovernmental are the culprits.

One only has to read a little history to prove the accuracy of these statements. The recent struggles in Austria, Belgium, Japan and Malta; the present

difficulties in France, England and Sweden are all shining examples of governments endeavoring to do as they please without reference to medical opinion. Some of the South American governments have made or are trying to make their doctors full time salaried servants of the government. Canada is faced with a government controlled hospital program which may or may not be developed in accordance with the wishes of the medical profession. In the United States where the doctors successfully fought off socialization of the profession a few years ago, the profession is constantly fighting further encroachments by government. Instead of a frontal attack the opponents of medicine are engaging in a piecemeal attack, trying to nibble off a little here and a little there.

Wherever the profession has been successful in its struggles, it has been because the doctors have stood together as a unit. Whenever there is disunity and the doctors start negotiating in separate groups there is disaster.

Many of the attacks against medicine and the medical profession are generalized at the international level. No national organization can successfully combat such attacks, but a world organization of doctors can.

The general assemblies of The World Medical Association have shown an increasing sense of unity among the doctors of the world. The influence that an organization representing nearly 700,000 doctors, who are largely united, is incalculable. Someone must be able to speak for the medical profession itself. A national association or an association

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having representation from only a few countries can have little influence at the international level. That is why there must be a World Medical Association with emphasis on the World.

Lay organizations trying to dominate medicine and make doctors mere technicians seem to fail to understand certain things.

First of all they do not realize that doctors are not trying to protect themselves and their profession but are trying to protect their patients. After all let those who are constantly attacking the medical profession show one other group that is constantly striving to remove the need for its own existence.

Second, they fail to realize that, as pointed out by Dr. Rolf Schloegell at Havana, it is a fallacy to try to standardize the effectiveness of any remedy and expect it to prove the most economical. The ultimate test lies in the relation of the patient and the experience of the doctor. Likewise it never occurs to them that both health and illness are highly individualized states which are not capable of terminological standardization.

Third, they ignore the fact that confidence in one's doctor is essential for good therapeutics, and a patient does not ordinarily have confidence in a doctor whom he is compelled to consult.

It is necessary in the words of Dr. Dag Knutson, as well as important that national medical associations "become strong, united and politically influential within their own countries as that is the only way to prevent further regulations and infringements on the rights of the patient and responsibility of the doctor."

However, that takes care only of the national problems and then only to a certain extent. The World Medical Association can be of assistance to national medical associations beset by problems involving legislation and political action; and being an international organization it can speak for the profession and the national associations before other international bodies. It can provide national associations with information about activities in other countries, and alert them to the projects of other international organizations which affect the very basis of medical economics and medical care, and thus threaten the national status from without.

The World Medical Association, is, therefore, not only an essential organization but it can be an increasingly valuable one if it has the united support of doctors in all its member countries.

All of this, however, is only one reason for The World Medical Association. It is and should be a leader in medical education. What other organization could take leadership in developing a new international medical emblem to protect medical groups and equipment in civil defense? Who can better act for the medical profession in drafting any decision with reference to international medical law? The Association can be anything its members want it to be, if they give it adequate support. Such support can be obtained only if the member associations take the responsibility of informing their individual members of the activities of The World Medical Association and what those activities mean to them individually.

The late Dr. Elmer L. Henderson, former president and Council member of The World Medical Association said during the Association's early days, "I believe in this." Let me make that our by-word and indoctrinate our colleagues with that philosophy. At the time the Declaration of Independence by the American colonies was being drafted, Benjamin Franklin said, "We must all hang together or most assuredly we shall all hang separately." Just as that statement was most apropos factually in that situation, so it also applies figuratively to the status of medicine today.

Personal Contact — The Heart of Our Membership Drive

In the first six months of 1957, the U. S. Committee welcomed more than 500 new members. Some came from advertisements published by the courtesy of medical journals; some joined at WMA exhibits at medical meetings; others responded to one of the special campaigns. But the great majority of new members joined the U. S. Committee because some older member personally urged or invited them to join. If every present member of the U. S. Committee were to make it his business to bring in one new member, not only would the present goal of 10,000 members be passed, but the effectiveness of the Association's program and services to the profession would be multiplied.

Membership application blanks may be obtained from any member of the Connecticut Committee.

BMA Establishes Supporting Group

During the past few months, the British Medical Association has been engaged in organizing a Brit-

ish Supporting Group for The World Medical Association. This Group came into being officially on July 1, 1957, after months of arduous activity on the part of the Association's Steering Committee.

The Steering Committee used a publicity campaign to stimulate the interest of the members of the British Medical Association in the activities of The World Medical Association. This was followed by invitations to its membership to apply for admission to the Supporting Group.

Categories of membership in the British Supporting Group include: individual qualified doctors and corporations, academic bodies and pharmaceutical firms.

The campaign was impeded somewhat by the medical profession's recent preoccupation with the remuneration dispute in connection with the National Health Service. However, it is anticipated that before the year is over, the British Supporting Group for The World Medical Association will become a vital and active unit devoted to promoting the objectives and activities of The World Medical Association.

SMA to Assist Young Doctors in Private Practice

The Swedish Medical Association has organized a group charged with trying to further the establishment of private practices for young doctors still working as junior staff physicians in hospitals.

A recently published survey, "Swedish Doctors and Their Work," revealed a preference and trend among the younger doctors to seek salaried positions rather than to establish themselves as private practitioners. The survey is a statistical analysis of a 1954-1955 questionnaire carried on jointly by the Swedish Medical Association and The World Medical Association's Socio-Medical Research Centre in Stockholm.

Medical School Costs Rise

The cost of operating medical schools in the United States has risen in the period of 1940 to 1955 from \$30 million to over \$160 million. Tuition payments cover only 15 per cent of these costs.

Founding of U. S. Pharmacopeia

On May 1, 1957 Theodore G. Klumpp, vice president of the U. S. Pharmacopeial Convention and a member of the Connecticut State Medical Society, unveiled a painting of "The Founding of the United States Pharmacopeia—The First General Convention, Washington, D. C., 1820." Special ceremonies attended the unveiling, including an historical sketch of events leading up to the founding and a brief biography of each of the eleven physicians who were responsible for the first U. S. Pharmacopeia.

Of the eleven delegates to this 1820 Convention, two, Joel Abbott and Eli Ives, were from Connecticut and a third, Lyman Spalding, was a dyed-in-the-wool New Englander. Born in Cornish, New Hampshire, educated at Harvard Medical School, it was Spalding who together with Latham Mitchell of Long Island contributed most notably to the founding of the U. S. Pharmacopeia.

Joel Abbott left his native town of Fairfield, it is reported, with his wife at the age of 18 and established an extensive practice in Georgia. The accomplishments of Eli Ives need no rehearsing for the benefit of Connecticut physicians. Yale University School of Medicine owes much to this prodigious worker. His final accomplishment brought him the presidency of the American Medical Association.

The painting itself is by Robert Thom who was commissioned by the U. S. Pharmacopeia Board of Trustees to depict the first convention. The eleven delegates are shown in the Senate chamber of the Capitol at Washington, some seated, others standing. Interested onlookers occupy the gallery. Wax candelabra and chandeliers afford the lighting. The tapestry and floor coverings lend a simple richness to offset the bare desks. It is a worthy memorial to this great event.

Minnesota Society Increases Dues

The House voted a \$15 increase in State association dues, from \$40 to \$55 annually. Four dollars of this total is earmarked for the physicians' assistance fund which was about depleted. The additional \$11 goes into the general fund. This dues increase becomes effective in 1958.

NEWS FROM WASHINGTON

Survey of Medical Research

Dr. Stanhope Bayne-Jones will be principal consultant to Secretary of HEW Marion B. Folsom on penetrating study of research accomplishments to be announced soon. Report is that Budget Bureau demanded an inventory to give an accounting of the millions channeled into medical research by Congress since 1948. Officials at HEW say forthcoming survey is strictly Secretary Folsom's idea. Due to be disclosed, when project itself is announced, are names of other consultants—now being selected—besides Dr. Bayne-Jones, who retired last year as chief civilian advisory on research to Army Surgeon General.

says the committee, "that a readjustment be provided . . . if this medical care for our veterans is to be maintained."

VA Medical Pay Raise Receding

Although weeks have passed since a salary increase for physicians, dentists, nurses and hospital managers of Veterans Administration was approved in committee, clearance of bill (HR6719) for House action has not been requested, as of August 5, and chances of enactment are fading. It appears certain that HR6719 will stay on shelf until present controversy over pay raises for more than 2 million Civil Service and postal workers is settled.

AMA Group Thinks VA Pay Raise Could Be Harmful

In its report recommending enactment of salary increases for Veterans Administration physicians, dentists, nurses and hospital managers, House Veterans Affairs Committee cited statistics showing that average income of doctors in private practice is more than 50 per cent above that of VA medical and dental personnel. Nevertheless, current issue of AMA's Federal Medical Services Newsletter intimates that bill's passage might attract doctors to VA payrolls in sufficient numbers to be detrimental to the public at large.

"The private physician, obviously, must rely on his own efforts and ability, instead of an act of Congress, to increase his income," it comments on Rep. George Long's (D-Louisiana) pay increase bill. "The prospect of an annual income of, say, \$8,950 to \$9,950—proposed for a full grade physician—without overhead and without collection problems, might well tend to reduce the number of physicians available for the nonveteran population."

Positions which would benefit by the increase total 6,034, of which 4,515 are medical, 794 dental, 636 nursing and 10 optometric. Statutory staff positions (33) and hospital managers (46) account for remainder. Additional cost to the government is estimated at \$5,997,000 for first year, rising to \$6,851,000 in fifth year. "It is absolutely essential,"

Broad Social Security Changes Proposed; Doctors Would Be Covered

More changes in the much amended social security law have been proposed in a bill (HR8883) introduced July 24 by Rep. Robert W. Kean of New Jersey, a Republican member of the House Ways and Means Committee before which the legislation would be heard. The bill is not an administration measure. Mr. Kean claimed that the amendments could be financed without increasing social security tax rates. His explanation: present full employment at higher wages and increased earnings of the Social Security Trust Fund. (However, another \$600 of income would be taxed at present rate.)

One of eight major points in his bill calls for the compulsory inclusion of physicians under the system, thereby making them eligible for old age and survivors insurance at age 65 or age 50 if totally and permanently disabled.

Other proposals include: (1) Increase maximum wage base from \$4,200 to \$4,800; under present contributory rates, there would be a \$13.50 a year increase in OASI taxes for earnings of \$4,800 or more, (2) pay benefits to dependents of those receiving disability payments, (3) authorize payments from the trust fund toward rehabilitation of those now receiving disability benefits, (4) increase ultimate benefits for those who continue to work after age 65 by a 1 per cent a year delayed retirement benefit,

(5) increase maximum family benefits for widows and dependent children from \$200 to \$296.25 a month, (6) increase widow's benefits from 75 per cent to 80 per cent of the worker's primary insurance amount, and (7) cover tips received as wages.

Mr. Kean said he is "very much in favor" of the coverage of physicians.

Survey of Medical Costs Under Public Assistance

The Bureau of Public Assistance reports that incomplete statistics indicate that hospital care is the most expensive item involved in the medical care of individuals supported by federal-state public assistance programs. Involved are four categories: the needy aged, blind, dependent children and permanently and totally disabled. In addition to helping States pay for these people's support, the U. S. also set aside additional money for their medical bills, money which must be matched in part by the States. The bureau's survey, for July-December, 1956, includes data from 20 States.

VA Using New Rehabilitating Treatment

A treatment devised to rehabilitate severely disabled older patients is producing promising results, Veterans Administration reports. Patients were victims of strokes, hardening of the arteries, arthritis or multiple sclerosis. After receiving maximum benefits from medical and surgical treatments, they were placed in special rehabilitation wards where an individual program was planned for each, under direction of a psychiatrist. Among other treatments, physical and corrective therapists used exercises to restore the patients' strength and coordination. At one hospital 50 of the 60 aged patients progressed enough to be discharged; at another 25 of the 130 left the hospital for jobs, 40 others were discharged, and 55 showed worthwhile permanent improvement.

PHS Names Consultant on Radiation Effects

The Public Health Service has appointed a special consultant on the public health aspects of radiation, who will serve as principal advisor to the surgeon general. Dr. Russell H. Morgan, radiologist-in-chief at Johns Hopkins University Hospital and professor of radiology at Johns Hopkins, was named recently by Surgeon General Burney.

Dr. Burney said Dr. Morgan has had more than 20 years of intensive training and experience in radiology, including teaching, research and practical application of existing knowledge to public health problems involving radiation. He formerly was associate professor at Chicago University and during World War II was with the PHS as radiology section chief, tuberculosis control division.

Dr. Morgan will help in the development of the PHS radiological health program which is concerned with protecting the population from harmful effects of radiation from various sources. He also will assist the surgeon general in coordinating PHS activities in research, epidemiological studies, environmental monitoring and technical assistance to the States.

VA Increasing Fees to Physicians In Home-Town Care Program

Veterans Administration is increasing fees to physicians under the home-town care program, and during the current fiscal year will spend in excess of half a million dollars more on this operation. VA already has reached agreement on the new schedules with medical societies or intermediary organizations in California, Colorado, Connecticut, Indiana, Maine, Massachusetts, New Jersey, Ohio, Oregon, Virginia, and Washington. Still under negotiation are fee schedules for Arkansas, Florida, Georgia, Idaho, Pennsylvania, South Dakota, Alaska and Hawaii.

In the 15 States, District of Columbia and Puerto Rico, where VA has no contracts covering physicians for home-town care, increases have been authorized in VA's "Catalog 5" charges. This is a guide to fees for the home-town care program, which has been accepted by physicians in these States. Now described as "Appendix A," it lists maximum charges for about 400 medical, surgical and laboratory services. Within the past two years total cost of home-town care has gone up \$2 million, reaching \$8.3 million for the last fiscal year.

Medical Care Cost Index Hits New High of 137.9

Consumer costs for health care continue to go up. For June, price index for medical care was 137.9, according to monthly report by Bureau of Labor Statistics. Doctors' fees, hospital bills, dental services and costs of drugs are combined under heading

"medical care." The figure was 0.6 per cent above May and 5.9 per cent higher than June of last year. Among cities, index range was from 129.5 in New York to 154.4 in St. Louis. (1947-49 = 100). In American cities since June, 1950 (outbreak of fighting in Korea), medical care costs to consumers have gone up by 30.8 per cent—greatest increase of any cost-of-living item. In same period, rent (next highest) is 24.2 per cent greater and food is up 15.6 per cent.

June's price index, for all items, was 120.2. Food was 116.2; apparel, 106.6; housing, 125.5; transportation, 135.3; personal care, 124.2; reading and recreation, 111.8; other goods and services, 124.6 and, as noted above, medical care 137.9.

Dr. Hess Named by President to Head Selective Service Committee

Dr. Elmer Hess of Erie, Pennsylvania, 1955 president of the American Medical Association, has been appointed by President Eisenhower as member and chairman of the National Advisory Committee to Selective Service on the Selection of Physicians, Dentists and Allied Specialists. He succeeds Dr. Howard Rusk of New York City, who has held the post since the committee's formation in the fall of 1950 when the doctor draft went into effect. The committee advises on the induction of medical and dental officers in the armed services.

Dr. Hess served in the Army Medical Corps in World War I in France. He has been president of the American Urological Association, and vice president of the Pan American Medical Association. He has made several missions abroad for the government, including one to Korea for the Army, and has been a member of the AMA Liaison Committee to the Secretary of Health, Education, and Welfare.

Conference Goal: Better Medical Treatment on TV

Conference on November 7-8 at Chicago's Sheraton-Blackstone will be first of its kind, a meeting of minds and ideas directed at improvement of television and radio presentation of medical subjects. It will be sponsored jointly by National Association of Radio and Television Broadcasters and American Medical Association. Broadcasters and representatives of medical societies, voluntary health organi-

zations and hospitals will be welcome at the conference.

"Public interest programs involving medical subjects are appearing more and more frequently on radio and television," said joint statement. "Both broadcasters and physicians want to be sure that such programs are interesting, informative and factually correct. We hope that this meeting will enable those concerned to do a better job."

Faster Controls Sought on Cigarette Filter Advertising

A House subcommittee has ended its public hearings on filter cigarettes, but the issue is far from closed. During the six days of hearings, the subcommittee attempted to establish that advertising used to promote filter cigarette sales in many cases is misleading or fraudulent. Through its report on the hearings and recommendations to other committees, the subcommittee is expected to:

1. Ask more money and personnel for the Federal Trade Commission so it can do a more effective job of policing cigarette ads.
2. Ask that the law be amended so FTC can ask federal courts for immediately effective injunctions against questionable ad slogans; under present law, the injunction sought does not become effective until all legal processes have been completed, which may take four years or more.

Last witness before the subcommittee was Robert T. Secrest, acting chairman of the FTC, who explained the agency's experiences in attempting to get the industry to drop misleading cigarette slogans. He said the injunction procedure was so prolonged and expensive that FTC developed a voluntary method. In 1952 a code was set up to govern cigarette advertising, and the industry was asked to make its copy conform. Since then, Mr. Secrest said, the FTC has obtained voluntary agreement from the industry to cease using 75 misleading slogans.

Mr. Secrest, however, indicated the cigarette advertising could be held in check more effectively if Congress would give the agency more money and staff (including at least one more physician), and would change the law to classify tobacco as a drug, thereby subjecting it to the same speedy injunctions used to enforce federal food and drug laws.

FROM OUR EXCHANGES

"Current Concepts in the Management of Osteoporosis" presents, according to Adam, some apparent contradictions (*Northwest Med.*, 56:3, pp. 291-297).

Perhaps it is allowable to emphasize the agreements and hold the questionable measures in mind for the future to solve. A high protein diet is a prime factor in preventing osteoporosis. The administration of vitamin D is a "ticklish" decision. The author seems to doubt its value and apparently regards it as harmful in some instances.

The important drugs in this condition are the hormones, estrogens and androgens (estradiol benzoate and diethylstilbesterol, testosterone propionate and methyltestosterone). Androgens give results essentially the same as those provided by estrogens, except that they produce definite, prolonged decrease in urinary nitrogen. In treatment the estrogens seem to have a greater effect on calcium balance than do the androgens, but the androgens exert a greater effect on protein metabolism than do the estrogens. The effect of vitamin B₁₂ has not been studied but is favored.

Orthopedic care in severe porotic patients is essential. Completely immobilizing a part of the body is bad treatment. The objective is to prevent fractures, avoid immobilization and undue bed rest. A hard bed, spinal braces (when tolerated) and directed exercise are suggested.

The author presents the treatment of osteoporosis in an empirical manner, because there is no set rule to follow nor a particular dosage to give. This is a condition in which the outcome of the patient is often dependent upon the physician's decision that a certain program of therapy is proper.

* * * *

In "A Review of Rocky Mountain Spotted Fever in Delaware" Flinn states that the disease is still endemic in that State (*Del. State Med. Jour.*, 29:2, pp. 41-43). He reports on six patients treated with antibiotics (chlor amphenicol, penicillin, tetracycline, etc.) and cortisone as an adjuvant. These six, in contrast with previous experience, recovered. Prompt adequate treatment with antibiotics, with or without steroids, almost certainly prevents death, and usually shortens morbidity. Diagnosis must be made promptly on the basis of history and clinical

findings. Animal inoculations of the patient's blood within the first few days may establish the diagnosis. Serological tests after treatment has been instituted may or may not be positive.

* * * *

The pain produced by metastasis or an inoperable malignant process frequently can be relieved by neurological procedures. It must be emphasized, however, that the primary disease must be accurately diagnosed; and that there must be assurance that the pain is due to malignancy and not to a secondary benign process. Furthermore it must be satisfactorily proven that the pain cannot be controlled by less radical measures, such as opiates or radiation. The sectioning of local nerves by any method as a general rule produces temporary relief and is useful only in selected cases. The least desirable procedure is that of prefrontal lobotomy, since analgesia does not occur.

Karavitis in a discussion of "The Neurosurgical Management of Pain in Malignant Disease" states that sympathectomy affords relief until the pathological process infiltrates adjacent somatic regions (*Rocky Mt. Med. Jour.*, 54:4, pp. 336-337). In the author's opinion the most useful procedure is that of spinothalamic tractotomy. The operation is done through the usual laminectomy exposure, and consists of selective cutting of the spinothalamic tract within the cord. Apparently the operation is feasible at all levels of the cord from the medulla, or even from the mesencephalon, down. When the chordotomy is properly done the patient loses the sensation of pain and temperature over the contralateral aspects of the body below the level of incision. If there is pain on both sides of the body a bilateral chordotomy is performed.

Complications are usually minimal and transitory in nature. There may be loss of sphincter control. Operation in the brain stem may be complicated by undesirable side effects, such as ataxia and dysesthesias and is therefore rarely indicated. An annoying complication is the recurrence of pain which may require reoperation of a more radical nature.

The neurological surgeon has much to offer the patient who is suffering intractable pain secondary to incurable malignant disease.

Parkinson's disease is a distressing condition. Patients who suffer from it can hope for some relief with recently devised methods of treatment.

The December number of the *Journal of the American Geriatric Society* contains eighteen articles dealing with various aspects of Parkinson's disease (IV: 12, pp. 1167-1319). Surgical targets such as the globus pallidus and chemopallidectomy seem to offer the best chance of relief. We can suspect that medication has small, or no value, in the treatment of this disease for it is not discussed. The entire approach in this symposium on Parkinson's disease hinges on the question of whether or not this disease can be treated neurosurgically, and in judging the results of particular surgical techniques. There seems to be some agreement that suitable operative procedures can yield consistently good results. It is said that the mortality rate is low as is the incidence of other complications.

* * * *

According to Beck, in a discussion of "The Blood Supply to Ischaemic Myocardium," the treatment of coronary artery disease has limitations (*Diseases of the Chest*, XXXI: 3, pp. 243-252). Prevention of the disease would make treatment unnecessary, but prevention now is not possible. The most effective treatment is that which delivers blood to the ischaemic myocardium. Surgical treatment is the only method that can accomplish this and should be applied to patients. The relief of pain is definite. Operation improves coronary artery circulation and reduces mortality from artery occlusion. The risk of the operation is slight.

Included is a discussion of various operative procedures that are available, aimed at improving the blood supply to the myocardium.

* * * *

The value of poliomyelitis vaccine is of immediate interest to the medical profession. Magoffin in an extensive analysis of "Epidemiologic Observations on the Safety and Effectiveness of Poliomyelitis Vaccine in California in 1955" draws some definite conclusions (*Cal. Med.*, 85: 2, pp. 79-86).

Among 227,000 children receiving Cutter vaccine, and the household contacts, the incidence of poliomyelitis was higher during the early postvaccinal period than in comparable age groups of the population at large. Among 238,000 children who received poliomyelitis vaccine made by other manufacturers early in 1955 no increase in poliomyelitis was ob-

served in the inoculated children or their household contacts.

Later observation on over 500,000 additional children vaccinated in California since September, 1955 with vaccine made under revised safety standards has uncovered no evidence of unsafe vaccine. Children who received a single inoculation of vaccine prior to the onset of the poliomyelitis season in 1955 showed an incidence 60 per cent less than the unvaccinated children. Among the children who received two inoculations an 85 per cent reduction was observed. The average reduction in paralytic poliomyelitis for the entire group of vaccinated children was approximately 75 per cent. Data on children vaccinated since September, 1955 with poliomyelitis vaccine made by methods now approved indicate that a similar overall effectiveness is being maintained.

The author confesses that there are many questions that still remain unanswered. They include such matters as to why a single dose is often effective, why the vaccine sometimes fails to protect, what is the optimum dosage schedule, how frequently and for how long in life should booster injections be given, etc.? In the meantime it can be asserted that the vaccine is safe and that it provides significant protection against paralytic poliomyelitis.

* * * *

Pheochromocytoma is one of the uncommon causes of hypertension. Gutman reports such a case in a 23 months old child. He describes the clinical course and reversal of hypertension to normal tension by surgical removal of the tumor (*Wis. Med. Jour.*, 56: 5, pp. 235-237).

The usual age of patients with this tumor is between 25 and 45 years. However, it has been found as early as the fifth month of age. (Dr. Gutman's case was 23 months old at the time of the removal of the tumor.) The right adrenal gland is more often involved than the left. In about 10 per cent of the cases the tumor tissue will occur in multiple foci.

The symptoms of pheochromocytoma tumor are variously reported. They commonly follow the pattern of the adrenogenital syndrome. However, sustained hypertension appears as a prominent finding in many case reports. Perhaps the chief interest of this particular patient who was alive and well at 26 years is the demonstration of survival in spite of one of the complications of hypertension (cerebral accident).

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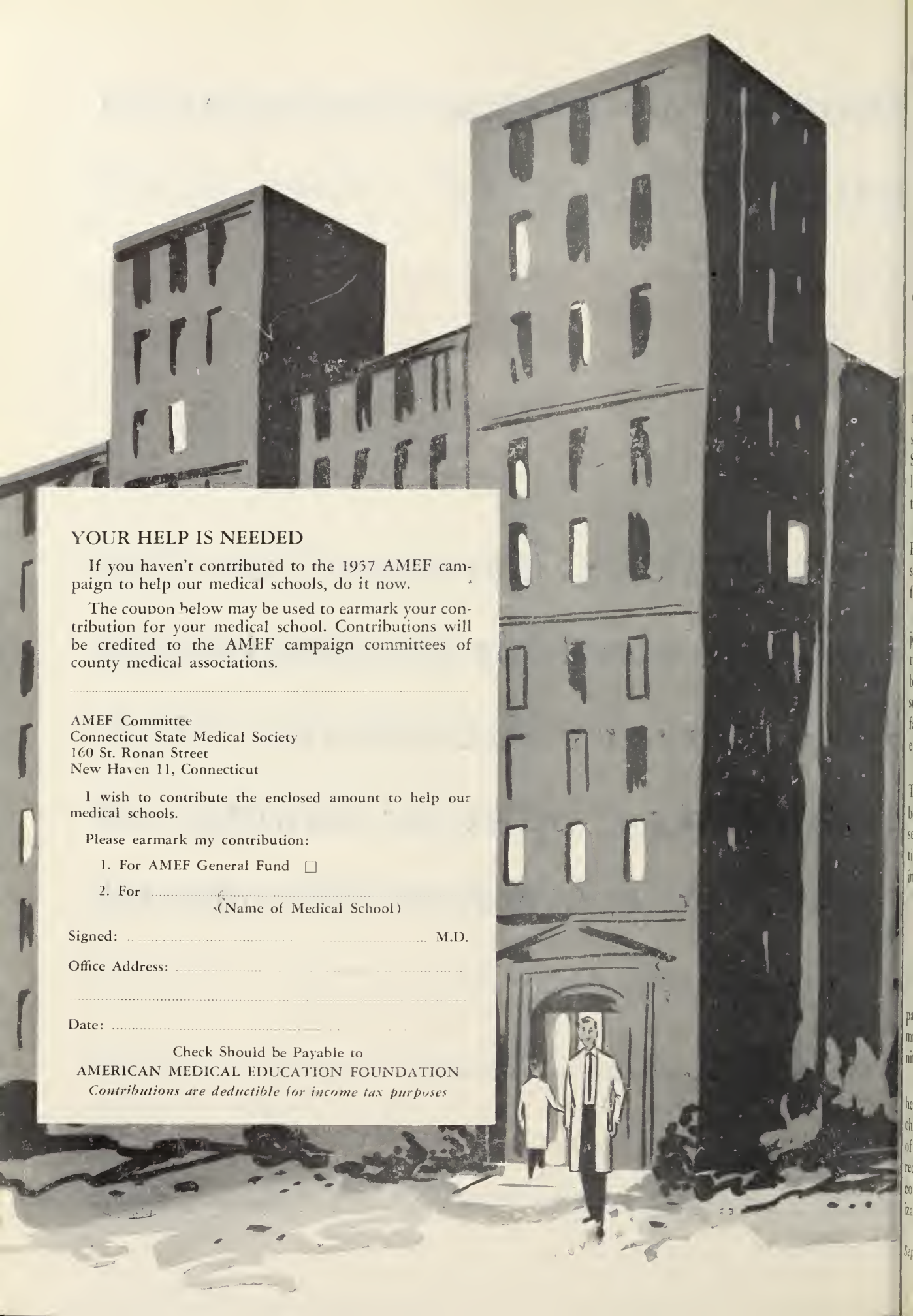
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Medical Television Topic of National Meeting

The American Medical Association and the National Association of Television Broadcasters will sponsor a two-day meeting on November 7-8 at the Sheraton-Blackstone Hotel, Chicago, on the use of local television and radio time by medical and voluntary health organizations.

Dr. David B. Allman, AMA president and Harold E. Fellows, president of NARTB recently issued a statement underscoring the importance of the conference.

"Public interest programs involving medical subjects are appearing more and more frequently on radio and television," the statement said. "Both broadcasters and physicians want to be sure that such programs are interesting, informative and factually correct. We hope that this meeting will enable those concerned to do a better job."

The fall conference is entitled "How to Use Local Television and Radio in the Health Field" and will be open to radio and television broadcasters, representatives of medical societies, hospital organizations, voluntary health organizations, and others interested in public interest health programs.

New Speaker's Bureau Handbook to Be Published

A new Speaker's Bureau handbook is being prepared under direction of the Public Relations Committee for publication and distribution to community organizations this fall.

The twelve-page booklet will include a variety of health topics which may be selected by program chairmen for meetings of their organizations. Names of speakers will not be listed in order that each request may first be referred to the respective county medical association. Subsequently the organization making the request will be notified concern-

ing the speaker and arrangements which should be made for his reception at the meeting.

In addition to health subjects, the topics will cover the development and community services of medical associations, growth of voluntary health insurance, and legislative and socio-economic problems in medicine.

Request cards will be prepared for inclusion in the booklets to assure complete information and the best possible service for speakers and program chairmen. County medical associations will be notified in advance of booklet distribution so that lists of speakers can be prepared for the project.

Community Services Slated for Consolidation by PR Committee

A program to consolidate four areas of community services in cooperation with county and local medical associations is currently being considered for early action by the Society's Committee on Public Relations.

Services slated for attention include emergency medical call plans, health exhibits, Speaker's Bureau activities and film showings and increased distribution of the Family Health Record, First Aid Chart, Emergency Medical Card and other service publications.

A recent report concerning evaluation of these services points out that "There are other activities which could be included for consideration, but it is felt that the four activities outlined present more than enough challenges to deal with at the present time."

The report outlines progress to date in each project area and states that a survey not yet completed indicates that 2,830 calls were received during 1956 by 12 of the 18 emergency call plans located in major population centers of the State.

In discussing Speaker's Bureau activities, the report states that "In all communities more people

are reading, hearing, and seeing (TV) more about health care than ever before. One consequence is that more people have questions about health—and M.D. speakers before community groups and health forums represent a medical court to which residents may appeal for authentic information.”

It is planned to implement the project in the four major service areas through field meetings and surveys in cooperation with local medical association committees.

AMA Sponsors PR Institute on Current Problems

The 1957 Public Relations Institute sponsored by the American Medical Association, August 28-29 at the Drake Hotel, Chicago, was attended by more than 300 executives of medical associations, committee chairmen and staff members.

Two panel discussions on public information programs for medical association activities marked the opening of the conference. Afternoon sessions of the first day included discussions of problems faced by large and small state and county associations, exchange of information from associations which have resolved some of the problems discussed, and development of solutions for new relationship problems.

The program for the second day of the conference included case histories and evaluation of grievance committee operations, a review of socio-economic and legislative problems, and showings of new films, health exhibits, radio transcriptions and publications available for use by local medical associations.

Pensions or Handouts? Food For Thought

SOCIAL SECURITY COSTS ARE GETTING OUT OF CONTROL.

Even in a political off-year, the shibboleth of Social Security apparently enjoys irresistible appeal on Capitol Hill. Since the Eighty-Fifth Congress convened five months ago, the lawmakers have introduced more than a hundred bills designed to broaden the program in one way or another. Representative John Dingell of Michigan, bearer of a name celebrated in welfare circles, is seeking to increase existing benefits and taxes on many now

covered. The ubiquitous Texan, Representative Wright Patman, urges that Washington provide retirement income for every U. S. citizen 65 or older. Not to be outdone, Representative Thomas Lane of Massachusetts has tossed into the hopper a measure to “provide a direct national pension of at least \$150 per month to all Americans who have been citizens 10 years or over.”

Such open-handed proposals invariably win acclaim, and usually more tangible rewards at the polls, for their sponsors. Only a few curmudgeons, indeed, ever have bothered to inquire into the ultimate cost of Social Security. Admittedly, the future is difficult to foresee. But even today it is increasingly evident that the whole welfare scheme is heading for trouble. The alarming fact is that years ahead of schedule, the growth of the Old Age and Survivors Insurance Trust Fund has come to an end. Indeed, at the moment it is paying out more than it is taking in. The unexpected deficit should serve as a red flag to the Treasury, the taxpayer and all those who are looking forward one day to receiving retirement checks of their own. However generous its motives, even a federal pension fund cannot forever go on incurring obligations which exceed its resources.

For years Washington has chosen to ignore this plain truth. Since its birth in the dark days of the depression, Social Security repeatedly has been made more liberal. By election-year leaps and bounds—in 1950, 1952, 1954 and 1956—Congress has added to the rolls new workers, notably civil servants and the self-employed, many of whom, after only 18 months of contributions, now are qualifying for lifetime pensions. So fast have the numbers grown that just last month flash bulbs popped in New York City as Secretary Marion Folsom handed the ten-millionth living recipient her first check. Moreover, since 1950 the maximum monthly payment has more than doubled—to \$108.50 for a retired worker, and \$162.80 for a married couple. In 1956 the minimum retirement age for women was lowered to 62. Even more significant, for persons 50 and older, the wholly new principle of compensation for physical disability was introduced.

Bi-partisan generosity with the taxpayers' money, moreover, seems far from ended. As noted, Congress has before it today a host of proposals for more expansive coverage. These measures, among other things, would add new beneficiaries: depend-

(Continued on page 857)

(Barron's National Business and Financial Weekly, 6-10-57. Reprinted from *Insurance Economics Surveys*, July, 1957.)

OBITUARIES

Howard Bulkeley Haylett, M.D.

1884 - 1957



Dr. Howard Bulkeley Haylett, leading physician of East Hartford, died at the Hartford Hospital May 1, 1957. Until a few weeks before his death Dr. Haylett was actively engaged in general practice in East Hartford for over 40 years, responding at any time of day or night to all calls, not only those of his own patients but the call of anyone in need of his help.

Dr. Haylett, son of the late Dr. James and Lilla Bulkeley Haylett, was born in Moretown, Vermont. After graduating from the University of Vermont Medical College in 1907 he interned at the Hartford Hospital and began practicing in East Hartford in 1917.

He was a member of the Consulting Staff of the Hartford Hospital, the Hartford Medical Society, the Hartford County Medical Association, the Connecticut State Medical Society, the American Medical Association, and the Connecticut Historical Society.

He was well known in a wide area as an authority on antiques and had one of the finest collections

of antique furniture in New England. His advice, often sought by his friends and medical associates, was always cheerfully given. As a collector, so as a practitioner of medicine he was satisfied with only the best, the genuine.

His honesty, his unselfishness, and his loyalty to his patients won him their love and affection, the true reward of the true physician. In the hospital these same characteristics brought him the respect and affection of all who worked with him.

Dr. Haylett leaves his wife, Marie Bosworth Haylett of East Hartford, and a brother, Harold A. Haylett of Burlington, Vermont.

John C. Rowley, M.D.

Arthur Weil, M.D.

1888 - 1957



Dr. Arthur Weil was born in New Haven July 20, 1888 and died in Memorial Hospital, New York City on May 5, 1957.

A graduate of Yale College in 1910 and New York University Medical School in 1914, his major interest had been the general practice of medicine in his

native city. He was also interested in the field of Public Health, having done special work for the New York City Department of Health. Concurrent with his private practice in New Haven, Dr. Weil served as United States Public Health Surgeon in this area and as Examining Physician at the Yale University Health Department. In World War I he volunteered his services to the Army, serving overseas as captain in the Medical Corps. In addition he had special interest in neurology and worked with Dr. Simon Goodhart of New York.

But such a recital of bare facts does not properly reflect the life of Arthur Weil, the family doctor. His devotion to his patients and the friendship and confidence that the families felt toward him were outstanding and will never be forgotten. He had the gift of carrying the weighty job of medical practice conscientiously, yet with a light touch.

Arthur Weil, the man, had many interests and all were characterized by warmth and geniality. Throughout his life, he maintained an interest in music which was a heritage of his family. My earliest recollection of him, before he was a doctor, was when he played side by side with his father in the Religious School Orchestra. His natural amiability won him friends in all walks of life, and these friendships were deep and sincere.

Dr. Weil is survived by his wife, Frances Steinbach Weil. The years of their very happy marriage were marked by great understanding of each other. Both Arthur and Frances suffered chronic and painful illness for years. Through this they both showed remarkable courage. They were able thus to give strength to each other. Few people who saw Arthur Weil's gracious smile and jaunty bearing knew that he was afflicted with cancer, which eventually led to an extensive operation, the complications of which were fatal.

His life and his work were marked by serenity and fortitude.

Bernhard A. Rogowski

Marguerite D. Shepard, M.D.

1908 - 1957

Marguerite D. Shepard of Bristol, Connecticut, a physician on the staff of Cedarcrest Hospital since January 1943, died April 29, 1957.

Dr. Shepard was born on October 25, 1908. She

received her Bachelor of Arts degree from Barnard College and after two years of postgraduate work entered the New York University College of Medicine, from which she received the degree of Doctor of Medicine. She interned at Christ Hospital, Jersey City, New Jersey, and was licensed to practice medicine in New York and Connecticut. She served as resident in tuberculosis at Belmont Hospital, Worcester, Massachusetts and at Bellevue Hospital, New York before coming to Cedarcrest.

Dr. Shepard was a member of the American Medical Association, the State and County Medical Societies and the American and the Connecticut Trudeau Societies. Her interest in her horses and her dogs made her well known to many additional friends with common interests. Dr. Shepard will best be remembered for the many years of service to her patients. Her medical associates and her patients will long remember her ready wit, kindness and devotion to duty.

Dr. Shepard is survived by her parents, the Rev. and Mrs. Charles N. Shepard of Bristol and New York, and by her sister, Miss Katherine Shepard of Washington, D. C.

Reginald C. Edson, M.D.

Douglas J. Roberts, M.D.

1892 - 1957



Douglas James Roberts, M.D. of Hartford and Vernon, Connecticut, died suddenly at his home March 12, 1957 of coronary thrombosis which was unexpectedly found associated with lymphatic leukemia.

Dr. Roberts was born in Burlington, Vermont, June 20, 1892. He received his medical degree from the University of Vermont in 1916 and received his postgraduate training at the Royal Victoria Hospital, Bridgeport General Hospital, and the Army X-ray School at Cornell. He served in the first World War in the American Expeditionary Force and was discharged in 1919 as a major in the Army Medical Corps.

He began the private practice of radiology in Hartford, Connecticut at the end of the first World War when he became associated with Arthur C. Heublein. He soon became a visiting radiologist at the Hartford Hospital. Skill in his specialty together with a friendly and genial personality early led to an outstanding leadership in radiology in and outside the State of Connecticut and in the social affairs of the community.

Dr. Roberts served as president of the Medical and Surgical Staff of the Hartford Hospital, as a member of many of the hospital staff committees, and as chairman of the Executive Committee. He also was associated in an active or consulting capacity with several other hospitals in Connecticut. He was a member of many national, sectional and state societies and was past president of the New England Roentgen Ray Society, the New England Cancer Society and the Hartford Medical Society. He had become particularly interested in radiation therapy and at the time of his death was president-elect of the American Radium Society.

Douglas Roberts had many interests and hobbies outside of his profession but none gave him greater pleasure than his collection of antiques which included unusual pieces of pewter and rare old clocks. These together with many excellent examples of period furniture were natural settings in the surroundings of an old New England farmhouse which he had restored to its original appearance. He was a member of the Connecticut Historical Society, the Antiquarian and Landmarks Society and the National Association of Clocks and Watches.

He was a lover of music and sang with many local groups. He himself was endowed with a fine baritone voice and sang in the choir of the St. John's Episcopal Church in Rockville where he was also a vestryman.

Dr. Roberts is survived by his wife, Hope Richardson Roberts; two sons, Dr. Douglas J. Roberts, Jr. who is practicing radiology in Hartford, and Ross R. Roberts; a daughter, Mrs. Jane Roberts Pastel; and a sister, Miss Dorothy Roberts. There are seven grandchildren.

The record which he has left is an enviable one. He will be missed by his associates and his many friends.

Ralph T. Ogden, M.D.

PENSIONS OR HANDOUTS?

(Continued from page 854)

ent parents, brothers and sisters, children in process of adoption, Gold Star Mothers and survivors of individuals who died before 1940. Other bills seek to raise, by varying amounts, the size of the monthly checks. Some propose to lower the age limits for eligibility—to as low as 55 under one bill. Finally, Mr. Dingell wants to increase from \$4,200 to \$6,200 a year the amount of earnings on which existing taxes and benefits are calculated, thus bringing in more revenue immediately and paving the way for larger disbursements.

However humanitarian, this Santa Claus spirit hardly could be less timely. For the cruel truth—unnoted in last month's ceremonies—is that the Social Security Administration is running through its money faster than anyone had dreamed. The first hint of trouble came in fiscal 1956, when the trust fund's net gain of \$1.4 billion fell some \$100 million short of original estimates. For the current fiscal year, too, the anticipated billion-dollar rise already has been scaled down by one-fourth. As for fiscal 1958, the forecast of the official soothsayers is that their coffers will swell by a mere \$120 million. Yet even this appraisal appears to sanguine. In April, as farmers, among others, began drawing their first payments, outlays spurted to an unprecedented \$664 million. At that rate, nearly \$8 billion a year, Social Security actually would run a deficit in fiscal '58.

One way to deal with this ever mounting burden of course, is to step up revenues. Mr. Dingell's measure is one attempt. However, it has some obvious defects. For example, it would increase the levies only on persons earning more than \$4,200. For those slated to bear the burden, the additional income, when and if received would be less than propor-

(Concluded on page 864)

OUR MEDICAL WORLD

Social Security in Belgium

In 1944 a Social Security law was adopted containing an article that provided power for the Minister to draft rules and regulations implementing the principles of this law which covered sickness and invalidity and providing for mutual insurance companies governed by the employers, employees and representatives of the insurance companies. The law did not include the medical profession as a representative governing body nor could the Minister draft a regulation to have it so included. The Social Security system was widely extended and the fund deficit had to be met by government subsidies. The original system was financed by funds from employers amounting to 19 per cent of the salaries he paid; workers paid 6 per cent of their wage; and the government added 15 per cent except in the case of miners for whom it added 60 per cent.

A year ago the Minister of Labor—a Marxist jurist—introduced into the legislature a series of regulations creating a state medical service for all insured persons. The doctor, to practice in this state system, would sign an agreement stating he would abide by all ministerial regulations now existing or to be issued in the future. The insured patient must obtain a permit from the insurance company before going to a doctor and for medical benefits other than visits or consultation; the doctor had to obtain authorization from the insurance company. The state exercised the right to determine whether or not the medicine prescribed by the doctor was necessary.

The medical profession reacted violently. The medical faculties joined in the movement for defense of the profession. The medical profession set up an Acting Committee commissioned to represent the doctors before the government and the insurance organizations.

This unity of purpose forced the government to request the medical profession to present its proposals for implementing the Social Security plan. Twelve doctors spent four months discussing the program acceptable to the medical profession with

six Ministers and 12 Secretaries. The agreement finally signed by the government and the medical profession provides that government may not interfere in the patient-doctor relationship in any way and agreed to accept no regulations that would affect this relationship.

The signing of this agreement necessitated modifying the Minister's regulations to bring them into accord with the agreement. Four months later, without any prior information to the medical profession, the newspapers announced that the government had sent a bill to Parliament authorizing the Minister to draft the regulations for the medical profession. This was a flagrant violation of the agreement between government and the medical profession.

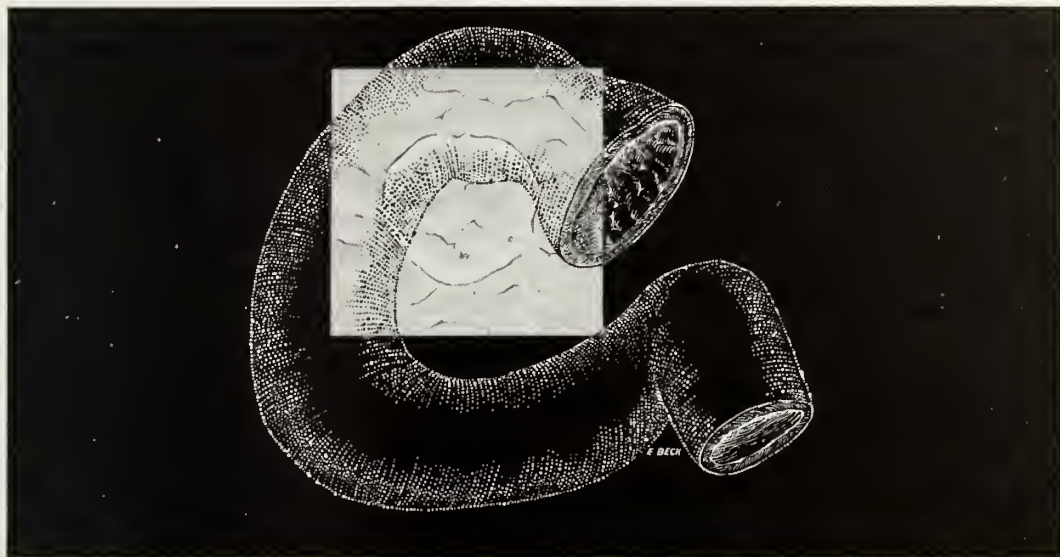
The medical association consulted the professors of law at the four universities and were able to have incorporated into the law a statement that the medical profession of Belgium can only be incorporated into the regulations with its consent. The bill was adopted and the association immediately notified the government that it refused consent to have the medical profession incorporated in the regulations.

In the past year the government has issued three decrees relative to sickness but not one of these can be implemented because the medical profession refuses to recognize them.

Prior to these developments the medical profession had been submissive in its attitude toward Social Security. This was a serious mistake as it indicated a defensive position which could only lead to defeat. Hence, an aggressive campaign was undertaken to provide the people with a medical assistance plan in accordance with the principles of the medical profession. This plan was made available not only to those insured under the state and mutual system but also to those who were uninsured. The association created a nonprofit society under public law. Doctors and patients are contracted through this society. The doctor agrees to accept a fixed rate for his services to the patients within certain wage scales. The insured patients may consult any doctor listed by the medical service and know before hand the fees the doctor will charge. Patients are furnished lists of the doctors which currently include 70 per cent of the doctors in the country. The doc-

Reported to, 10th General Assembly of World Medical Association at Havana, Cuba, October, 1956, by Dr. P. Glorieux.

RELIEVES THE GNAWING ACHE



Pro-Banthine® provides rapid control of pain in peptic ulcer

In a two-year study¹ by Lichstein and co-workers, documented by intensive personal observation and by follow-up studies, Pro-Banthine (brand of propantheline bromide) often brought immediate relief of ulcer pain. Patients (11 per cent) who did not respond satisfactorily to Pro-Banthine therapy had "anxiety manifestations of psychoneurotic proportions."

In addition to frequent immediate symptomatic relief, Pro-Banthine reduces gastrointestinal motility and diminishes the secretion and acidity of gastric juice, all-important factors in the generation and aggravation of peptic ulcer.

These actions of Pro-Banthine and its demonstrated effectiveness in accelerating ul-

cer healing²⁻⁵ mark the drug as a most valuable adjunct in the treatment of peptic ulcer.

The suggested initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. An increased dosage may be necessary for severe manifestations and then two or more tablets four times a day may be prescribed.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

1. Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: *Am. J. M. Sc.* 232:156 (Aug.) 1956.
2. Sun, D. C. H., and Shay, H.: *Arch. Int. Med.* 97:442 (April) 1956.
3. Rafsky, H. A.; Fein, H. D.; Breslaw, L., and Rafsky, J. C.: *Gastroenterology* 27:21 (July) 1954.
4. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: *Gastroenterology* 25:416 (Nov.) 1953.
5. Silver, H. M.; Pucci, H., and Almy, T. P.: *New England J. Med.* 252:520 (March 31) 1955.

SEARLE

tors may register in two categories. The first provides minimal rates for professional services; the second is a 50 per cent higher fee rate. In this way the national service of the doctors complies with social obligation and fully respects the patient-doctor relationship without any interference from the state or a nonmedical organization. It has received wide recognition.

This experience proves that the medical profession through its association can defend itself if it wishes to expend the effort to do so. It must recommend reasonable programs that are constructive and show that the profession is conscious of its obligations; it proves that no government can impose rules upon the medical profession that violate its principles; it shows that united efforts of the medical profession will result in a service for all who are ill and peace in the medical field.

Social Security in France

During the past years the Social Security institution has provided 80 per cent reimbursement for the doctor treating insured persons. However, in reality, because of the fee for service scale established by these institutions, this has amounted to only 40 to 50 per cent of the doctor's legitimate fee. Current recommendations would freeze the reimbursement at this current scale with the steadily rising cost of living, doctors would have economic difficulties in supporting themselves. About 90 per cent of the population is covered by insurance. The doctors desire the right to set a just fee for service for the care of those patients able to pay for medical services.

Unfortunately the medical profession in France is not as united and strong in its purpose as the Belgian medical profession. The Minister of Labor encourages the disunity of the profession.

In addition the Minister wants to introduce a hospital reform bill extending the clinics. The profession opposes the bill.

The Social Security deficit is 40 million francs. Modern scientific medicine is expensive and cannot be otherwise. However, the government representatives want the people to believe that this high cost is due to the fees paid the doctor while statistics show that the increase in these fees are minimal.

Whenever there is conflict between the medical

profession and the government over a recently established system, the government is likely to accept the contracts offered by the medical profession with the condition that the profession will do nothing to impede future social legislation. This is a dangerous concession. Doctors in France also are sued for refusing to give medical care when the patient has gone to two or more other doctors for care and disclaimed the doctor being sued as his doctor.

THE DOCTOR'S OFFICE

Irwin W. Becker, M.D. announces the opening of an office for the practice of general surgery at 88 Goodwin Street, Bristol.

Peter J. Cavallaro, M.D. announces the opening of an office for the practice of urology at 99 Sherman Avenue, New Haven.

Louis A. Coulson, M.D. announces the opening of an office for the practice of orthopedic surgery at 309 State Street, New London.

Michael L. Fezza, M.D. announces the opening of an office for the practice of general medicine at 1324 Dixwell Avenue, Hamden.

Raymond B. Keefe, M.D. announces the opening of his office for the practice of pediatrics at 525 Windsor Avenue, Wilton.

Rudolph V. LaMotta, M.D. announces the opening of his office for the practice of internal medicine at 792 Farmington Avenue, Hartford.

Herbert M. Magram, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 100 Broad Street, Middletown.

Mark Solomkin, M.D. takes pleasure in announcing that Walter F. Tauber, M.D. will hereafter be associated with him in the practice of medicine at 750 Main Street, Hartford. Practice limited to obstetrics and gynecology.

Salvatore Staffieri, M.D. announces the opening of an office for the general practice of medicine at 116 Main Street, Danbury.

Fowler F. White, M.D. announces the opening of an office for the general practice of medicine at 1001 Farmington Avenue, Hartford.

John C. Wright, M.D. announces the opening of an office for the general practice of medicine in association with Dr. Robert K. Butterfield at 257 East Center Street, Manchester.

Reported to 10th General Assembly of World Medical Association at Havana, Cuba, October, 1956, by Dr. M. Poumailloux.



little

How to win friends ...

NOW!
1 1/4 GR. SIZE



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1 1/4 grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.

WOMAN'S AUXILIARY

President
Mrs. Paul Winslow Tisher, New Britain
President-Elect
Mrs. Charles Murray Gratz, Greenwich
First Vice-President
Mrs. Daniel P. Samson, Thomaston
Second Vice-President
Mrs. Saul Karpel, New London



Recording Secretary
Mrs. Norman Gardner, East Hampton
Corresponding Secretary
Mrs. Charles N. Sullivan, New Britain
Treasurer
Mrs. J. Alfred Wilson, Meriden

State Insignia

Our State President, Mrs. Paul W. Tisher, was authorized to ask Mrs. Nicholas Marinaro, Newington, to copy the State President's Pin which she had previously designed. A master die has been made from the new drawing and subsequently the State stationery and *Quarterly* will use this insignia. We appreciate Mrs. Marinaro's outstanding talents and her willingness to use them for the Auxiliary.

Medical Advisory Committee of Connecticut State Medical Society to the Woman's Auxiliary

Dr. Winfield O. Kelly, Norwich.
Dr. Oliver Stringfield, Stamford.
Dr. Ralph Ogden, Hartford.

Dates to Mark On Your Calendar

Monday, September 30—Board of Directors Meeting, Colonial Inn, Hamden.

Wednesday, November 6—Semi-Annual Meeting, Hotel Statler, Hartford.

Monday, January 13 or 27—Board of Directors Meeting.

Monday, March 24—Board of Directors Meeting.
Annual Meeting—Bridgeport. Last of April or first of May. Date unconfirmed as yet.

In Memoriam

Mrs. Ralph J. Lenoci	Bridgeport
Mrs. Voye Paul	Stamford
Mrs. Bernard Spillane	Bloomfield
Mrs. Carl F. Vernlund, Sr.	West Hartford
Mrs. Philip Parshley	West Hartford
Mrs. Oliver Stringfield	Stamford
Past President, Fairfield County	

State Budget

May 1, 1957 to April 30, 1958

INCOME ITEMS

Members dues—1,193 members @ \$3.....	\$3,579.00
CMS contribution for Quarterly item.....	400.00

Total	\$3,979.00
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EXPENDITURES

1. Officers

President—telephone, travel	
postage	\$450.00
President-Elect—telephone,	
travel, postage	200.00
Recording secretary—mimeo.	50.00
Corresponding secretary—office	
supplies	350.00
Treasurer—audit and bond.....	90.00
President's pin	25.00

Total	\$1,165.00
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2. Dues

National—1,193 members @	
\$1	\$1,193.00
Connecticut Health League	10.00
World Medical Association	25.00
CSM Society—Art chairman	50.00
AMEF contribution	100.00

Total	\$1,378.00
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3. Quarterly	700.00
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4. Hospital and Program—Annual and	
Semi-Annual Meetings	225.00

5. Committees	325.00
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6. Discretionary Fund	186.00
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Total	\$3,979.00
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Two years ago a voucher system was instituted and works in the following manner. All vouchers and supporting bills must be sent to the finance chairman first. This is necessary as it gives her an opportunity to check for accuracy and to keep all accounts within the allotments allowed in the budget.



**Look at both
sides of a
bottle of 7-Up**

Why look at the *back* of a 7-Up bottle?
Here's why. On the back of the bottle are listed all the ingredients of this sparkling, crystal-clear drink.
This isn't *required*—or even usual—but 7-Up is proud to do it. Proud to let you see what a pure and wholesome drink it is. Seven-Up is *so* pure and wholesome, folks of all ages can have it. It is truly the *All-Family Drink*.

Nothing does it like Seven-Up!
The Seven-Up Bottlers of Connecticut



TEETHING IS EASIER
When you prescribe
DENTOCAIN TEETHING LOTION

FORMULA—	Alcohol	70%
	Benzocaine	10%
	Chloroform, 4 mins. per fluidounce.	

Easier on the Baby . . .

DENTOCAIN TEETHING LOTION makes it easier to go through the troublesome teething period. A small amount, applied with gentle massage, brings quick, soothing relief to irritated and inflamed gum tissue, aids in getting infant back to sleep.

Easier on the Mother . . .

By providing more comfort and extra sleep for the baby, DENTOCAIN TEETHING LOTION grants the mother greater peace of mind and several additional hours of necessary rest.
DENTOCAIN has also been useful in providing temporary relief for pain of adult toothache.



Dentocain Co., Hartford, Conn., U.S.A.

Professional samples and descriptive literature sent on request.

The finance chairman signs and numbers all vouchers, makes all allocations, then forwards them to the president for her signature, after which they are sent to the treasurer for payment. Vouchers must be made out in triplicate (original and two copies). The finance chairman will be glad to answer questions regarding the budget or voucher system.

(Mrs. Alfred B.) Vera Sundquist,
Finance Chairman

Delegates to 1957 Annual Convention New York City

Mrs. Paul Winslow Tisher, presidential delegate; Mrs. Charles M. Gratz, Mrs. F. Erwin Tracy, Mrs. Creighton Barker, Mrs. E. Roland Hill, Mrs. Saul Karpel, Mrs. William Sinton, Mrs. Dewey Katz, Mrs. John N. Gallivan, Mrs. Joseph Bruno, Mrs. Harold Irwin, Mrs. Jerome Kirschbaum, Mrs. Emil Karlovsky.

Alternates: Mrs. Barnett Freedman, Mrs. Michael Yoburn, Mrs. Frederick J. Fagan, Mrs. Daniel P. Samson.

From the 1957 National Convention

NATIONAL AUXILIARY TO BE INCORPORATED

Upon the advice of the Law Department of AMA the convention body voted that the Woman's Auxiliary AMA be incorporated and that assistance of the Law Department be requested in preparing the necessary forms. This will be presented at the 1958 Convention and action taken thereon.

REVISIONS

The proposed revisions to the constitution and to the by-laws were presented to the convention. It was voted that no action be taken on the revisions in view of the proposed plan of incorporation but that the 1957-58 Committee on Revisions be instructed to work with the AMA Law Department on complete revisions to conform with the above plan.

1958 NOMINATING COMMITTEE

The following were elected to serve as the Nominating Committee at the 1958 Convention: Mrs. Robert Flanders, New Hampshire, Chairman; Mrs. Clark Bailey, Kentucky; Mrs. V. R. Frederick, Ohio; Mrs. John M. Chenault, Alabama; Mrs. Leif G. Jensen, New York; Mrs. Lawrence Rapee, District of Columbia; Mrs. Oscar W. Robinson, Texas.

1958 CONVENTION

San Francisco will be the locale of the 1958 Convention, June 23-27. Headquarters for the Auxiliary will be at the Hotel Fairmount. Details as to program, hotel reservations, and general information will be available shortly. In the meantime, please mark your calendar accordingly.

CONTRIBUTIONS BY THE NATIONAL AUXILIARY

*To the American Medical Education Foundation..\$6,677.00	
To the American Medical Education Foundation in memory of Mrs. Charles Trabue, III, Southern Regional AMEF chairman.....	25.00
To the Student AMA Loan Fund.....	100.00
To the Student AMA Auxiliary.....	100.00
To the World Medical Association.....	100.00
To the Committee on Careers, National League of Nursing	100.00
To the Committee on Careers in Medical Tech- nology	100.00
To the Crusade for Freedom.....	100.00

*This is in addition to the amount presented to AMEF at the Wednesday, June 5, 1957 luncheon, contributed by the county and state auxiliaries, making a grand total for the year of \$113,540.56.

PENSIONS OR HANDOUTS?

(Continued from page 857)

tional to the outgo. A prudent man in the bracket would fare better by taking out private insurance, tailored to his own particular needs. Even without further deductions from his wages, the taxpayer now must carry a relatively heavy load. Today, Social Security exacts 2¼ per cent of everything a job holder earns up to \$4,200, and an equal amount from his employer. Furthermore, the bite is scheduled to get worse. In 1960 the payroll tax automatically will rise to 2¾ per cent; by 1975 it will have reached 4¼ per cent. The quest for Utopia, it seems comes higher than advertised.

Beyond a doubt, security in old age is a desirable goal, for the individual and for society. However, the question of cost simply cannot be ignored. As the latest figures reveal all too clearly, the government program is reaching the point of diminishing returns. Despite the wishful thinking of zealous politicians . . . the cornucopia, after all, is not inexhaustible. In the light of recent experience, then, the U. S. surely needs to call a halt to helter-skelter and misguided philanthropy. Otherwise, the nation one day is apt to discover that in trying to bestow on some a greater measure of security than they have earned, it has robbed others of their due.

for "This Wormy World"



Pleasant tasting

'ANTEPAR'® brand

PIPERAZINE

SYRUP • TABLETS • WAFERS

Eliminate **PINWORMS IN ONE WEEK**
ROUNDWORMS IN ONE OR TWO DAYS

PALATABLE • DEPENDABLE • ECONOMICAL

'ANTEPAR' SYRUP - Piperazine Citrate, 100 mg. per cc.

'ANTEPAR' TABLETS - Piperazine Citrate, 250 or 500 mg., scored

NEW 'ANTEPAR' WAFERS - Piperazine Phosphate, 500 mg.

Literature available on request



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL MIDDLETOWN, CONNECTICUT

Medical Education Program of Noon Conferences for September, 1957

- Monday, September 2
Holiday — no meeting
- Wednesday, September 4
Tumor clinic 10:00 A. M.
- Friday, September 6
Grand rounds
- Monday, September 9
Clinical pathological conference
- Friday, September 13
Grand rounds
- Monday, September 16
No meeting
- Friday, September 20
Grand rounds
- Monday, September 23
S. R. Lipsky, M.D.
Advances in atherosclerosis
- Friday, September 27
Grand rounds
- Monday, September 30
Saul A. Frankel, M.D.
Management of head injuries

THE NEWINGTON HOME AND HOSPITAL FOR CRIPPLED CHILDREN Newington, Connecticut

The following change has been made in the Clinical program for September:

Monday, September 9, 1957, 7:30 P. M. The water content of human fascia, Philip Radding, M.D.; Basic principles of research for establishing cause and effect relationships, Mr. Dorian Shainin.

There will be no program in October because of the annual meeting. We shall advise you in September of the programs for November and December.

Congress of International Society of Orthopedic Surgery
and Traumatology
Barcelona, Spain
September 16-21, 1957

Preliminary Program

NEW ENGLAND TUBERCULOSIS CONFERENCE Griswold Hotel, Eastern Point, Groton, Connecticut September 12-14, 1957

- Thursday, September 12
- 3:00 Registration
 - Meeting of Governing Council
 - Meeting of the Massachusetts Conference of Tuberculosis Workers
 - 5:00 Social hour (dutch treat)
 - 7:00 Dinner
 - Welcome: James J. Powers, M.D., president of Conference; Mrs. R. Samuel Howe, president Connecticut TB Association; Verne E. Dewey, First Selectman, Groton, Connecticut
 - 9:00 Fashion parade
- Friday, September 13
- 9:00 Registration
 - 10:00-12:30 "The Board Goes Into Executive Session"
 - Setting: The Eastern Point TB and Health Association, Inc., Groton, Connecticut
 - Presiding: Edward J. Gallagher, president
 - Moderator: Mayhew Derryberry, PH.D., USPHS
 - Resource Board members from:
 - Maine-New Hampshire
 - Vermont-Massachusetts
 - Rhode Island-Connecticut
 - Recorded: (to be announced)
 - Audience participation
 - This session for volunteers only
- Friday, September 13
- 10:00-12:30 "Tuberculin Testing Today"
 - Moderator: Kenneth I. E. Macleod, M.D., Commissioner of Health, Worcester, Massachusetts
 - Panelists: Alice Porter, NTA.
 - Arnold Rilance, M.D., tuberculosis control officer, New Haven, Connecticut
 - Robert Kerr, M.D., executive director, New Hampshire TB Association
 - Regina Lowenstein, NTA
 - Edward Sierks, NTA
 - 1:00 Luncheon
 - 2:30-4:30 "Eastern Point TB and Health Association Meeting Reconvenes"
 - Moderator: Mayhew Derryberry, PH.D.
 - Agenda: Report of Recorder on morning session
 - Discussion of problems as determined by audience
 - Summarizer: (to be announced)
 - 2:15-4:00 "Rehabilitation Team at Work"
 - Chairman, Ann Switzer, associate director, Connecticut TB Association
 - Team coordinator: James S. Peters, PH.D.
 - Participants: (to be announced)

effective vulvovaginal therapy

trichotine[®]

a detergent... a bactericide and fungicide...

an antipruritic... an aid to epithelization...

an aesthetic and psychosomatic adjunct

Trichotine douches — incorporating the multiple advantages of sodium lauryl sulfate with the recognized values of other specific or adjunctive agents — may be prescribed as often as required in cases of nonspecific vaginitis and leukorrhea, subacute and chronic cervicitis, senile vaginitis, trichomoniasis, and moniliasis; hot packs are often quickly effective in pruritus vulvae.

Concentrated solutions are useful for clean-up or swab treatment in the physician's office.

VACID

the 24-hour vaginal pH stabilizer

The therapeutic value of continual maintenance of normal vaginal pH (4.0 to 4.5) is widely recognized in the treatment of monilial, trichomonal, and nonspecific bacterial infections and in cervicitis.

One Vacid insert suppository will hold the pH of the vagina at the normal physiologic level for 24 hours. Symptomatic relief is noted usually the first day and progressive improvement continues until Doderlein bacilli replace the infecting organisms — usually within 7-14 days.

Samples and literature on request... Full details in PDR.

The Fesler Co., Inc. Stamford, Conn.

4:14-5:15 "Telling the Story"

Chairman, Gerald Rogovin, assistant director, New Haven Area TB and Health Association

Participants: F. J. Schipper, Argus Associates

Don Lacey, Argus Associates

Robert Frankes, vice president, Corbett Press

7:30 Dinner is served

Presiding: James J. Powers, M.D., president of Conference

Greetings: William J. Lahey, M.D., president of Connecticut Trudeau Society

Speaker: Seldon D. Bacon, director, Yale Center of Alcohol Studies, chairman of State Commission on Alcoholism

Saturday, September 14

9:30-10:00 Showing of NTA film—"Are You Positive"

Remarks by Edward Sierks, NTA

10:15-11:00 "Let's Take a Look at Seal Sale Cost"

Chairman (to be announced)

Discussion leader: Elliot Curtis, NTA

"How Can You Further Medical Education and Research"

11:00-12:45 Chairman: R. C. Edson, M.D., medical director, Cedarcrest Sanatorium, secretary, Connecticut Trudeau Society

Participants: Edward J. Welch, M.D., president, Massachusetts Trudeau Society

Frank W. Webster, executive secretary, American Trudeau Society

Other participants to be announced

1:00 Annual luncheon—business meeting of Conference

Presiding: James J. Powers, M.D.

"What Went On"

Summarizer: (to be announced)

Make your reservations early.

ELEVENTH CONNECTICUT POSTGRADUATE SEMINAR IN PSYCHIATRY AND NEUROLOGY, INC.

September 18, 1957 - April 16, 1958

Sponsored by the Department of Mental Health of the State of Connecticut and the Department of Psychiatry, Yale University School of Medicine, in cooperation with The Institute of Living, Yale-New Haven Medical Center, U. S. Veterans Administration Hospital and Clinics, Connecticut State Hospital, Fairfield State Hospital, Norwich State Hospital, Mansfield State Training School and Hospital, Southbury State Training School.

The Connecticut Postgraduate Seminar in Psychiatry and Neurology is planned and designed to meet some of the needs of the physicians whose interests are mainly those of psychiatry, neurology, and related fields of medicine.

Since some parts of the Seminar program will, of necessity, be held to a limited number, applicants are advised to register early. The chairmen of such courses reserve the right to make such limitations as they deem necessary.

There are no charges or fees for attending the whole or any part of the Seminar.

Those desiring to attend the entire program, or any part of it, may apply to the Office of the Assistant Dean for Postgraduate Medical Education of Yale University School of Medicine, 333 Cedar Street, New Haven 11, Connecticut.

HARTFORD HOSPITAL

Saturday Morning 11 o'clock Guest Speakers

September 28 to December 14, 1957

September 28

S. J. Thannhauser, M.D., emeritus professor of medicine, Tufts University School of Medicine

Case presentation

October 5

William Sweet, M.D., associate visiting neurosurgeon, Massachusetts General Hospital; associate professor of surgery, Harvard Medical School

Research advances in neurosurgery

October 12

John Sheldon, M.D., professor of medicine, University of Michigan School of Medicine

The treatment of asthma

October 19

Lester Adelson, M.D., pathologist and chief deputy coroner, County of Cuyahoga, Cleveland, Ohio

The heart and cardiac massage

October 26

John McL. Morris, M.D., associate professor of gynecology, Yale University School of Medicine

10 A.M. Factors influencing the use of radiation

11 A.M. Endocrine assays—indications and present status

November 2

Ralph Alley, M.D., associate professor of surgery, Albany Medical College

Evaluation and treatment of chest trauma

November 9

Juan Taveras, M.D., senior roentgenologist, Neurological Institute, New York City

X-ray findings of brain and skull with reference to angiography

November 16

Howard F. Root, M.D., physician-in-chief, Deaconess Hospital, Boston; associate in medicine, Harvard Medical School

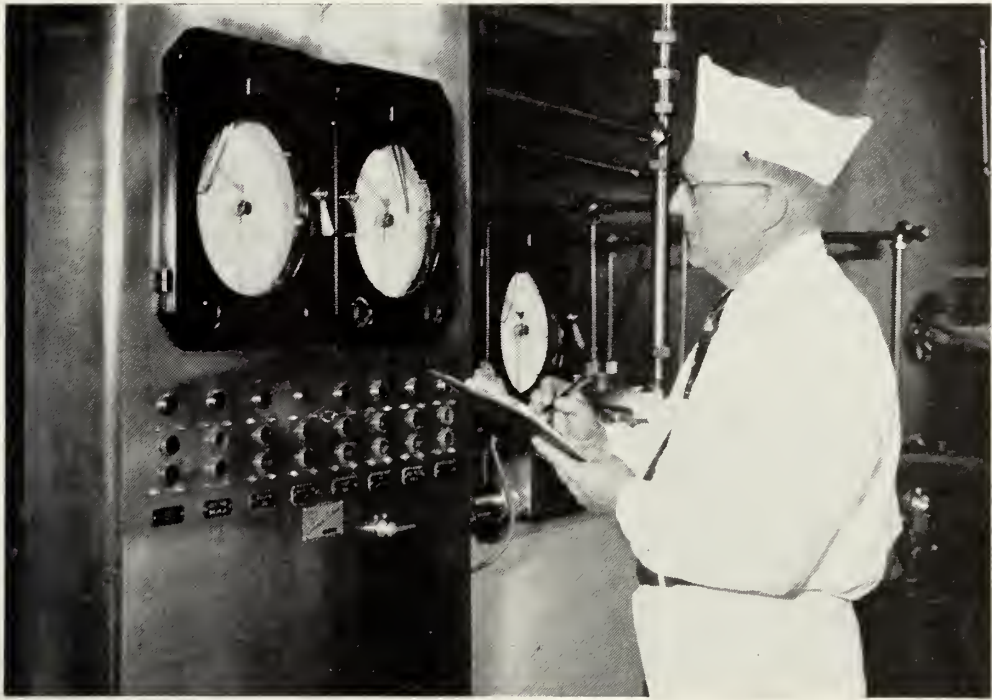
The control of diabetes mellitus today (National Diabetes Week)

November 23

Hartwell Harrison, M.D., clinical professor of G-U surgery, Harvard Medical School

Renal transplantation

The result is Sealtest Quality



**Homogenized
Vitamin D Milk
Vitamin D
Fat-free Milk
Buttermilk
Chocolate Milk
Cottage Cheese
Sweet Cream
Sour Cream
Butter**

► Shown here is just one step of the Sealtest system of quality control which safeguards the purity and excellence of Sealtest Milk and other Sealtest dairy products.

In hospitals, schools, industrial or public cafeterias . . . or in the home, the Sealtest emblem is an assurance of the most exacting standards.

NEW HAVEN DAIRY
New Haven

BRYANT & CHAPMAN
Hartford

Bridgeport, New Haven, Waterbury, Hartford, Manchester, Melrose,
New Britain and New London

GENERAL ICE CREAM DIVISION
National Dairy Products Corporation



November 30

E. Myles Standish, M.D., attending dermatologist, Hartford Hospital

The skin (Kodachrome presentation)

December 7

10 A. M. Schuyler G. Kohl, M.D., associate professor of Ob-Gyn, State University of New York College of Medicine, Brooklyn

Evaluation of obstetrical and newborn services

11 A. M. Research at Hartford Hospital—a progress report

December 14

Harry Shwachman, M.D., associate professor of clinical pediatrics, Harvard Medical School; chief, Chronic Nutrition Clinic, Children's Hospital, Boston

Cystic fibrosis

International Congress of Military Medicine and Pharmacy
Beograd and Opatija, Yugoslavia
September 29 - October 5, 1957

World Medical Association
Istanbul, Turkey
September 29 - October 5, 1957

AMERICAN MEDICAL WRITERS' ASSOCIATION

(Affiliated with the American Association for the Advancement of Science, Established 1848.)

The America's only Association exclusively devoted to improvement in the communications of medicine and allied sciences.

14th annual meeting, Sheraton-Jefferson Hotel St. Louis, September 27, 1957; Workshop September 28 (St. Louis Daylight Time.)

THE AMERICAN FRACTURE ASSOCIATION

18th annual meeting 1957, Monday, September 30, Tuesday, October 1, Wednesday, October 2. Hotel Cortez, El Paso Texas. Approved category II by The American Academy of General Practice. The University of Texas Postgraduate School of Medicine, El Paso Division, Ralph H. Homan, M.D., director, Sunday, September 29, 1957, 8:30 A. M. to 4:30 P. M. The El Paso County Medical Society (Turner) Home, 1301 Montana Street, El Paso, Texas. Approved category I by The American Academy of General Practice.

AMA TO STAGE FALL RURAL HEALTH MEETING

How to develop more effective rural health programs will be the chief topic of concern at the American Medical Association's second study conference October 4 and 5

for chairmen and members of state rural health committees. Sponsored by the Council on Rural Health, the conference will again be held at Purdue University.

International Congress of International Society of Angiology
Atlantic City, N. J.
October 10-13, 1957

AMA CONFERENCE ON NUTRITION IN PREGNANCY

Because nutrition plays such an important role in all phases of reproduction, the AMA's Council on Foods and Nutrition has selected "Nutrition in Pregnancy" as the title of its 1957 symposium. The meeting will be held October 11 at the University of Missouri Medical Center, Columbia, Missouri. Joint sponsors with the AMA are the University of Missouri Medical School and Adult Education and Extension Service and the Boone County Medical Society.

WATERBURY MEDICAL ASSOCIATION HISTORICAL EXHIBIT

In connection with the Centennial celebration of the Waterbury Medical Society there will be an historical exhibit at the Castle Memorial Building, Waterbury, October 23-25, 1957.

This exhibition will consist in part of a display of instruments, photographs, medications, books, historical documents and any other material relating to medicine in Waterbury in the past 100 years. There will be additional features such as addresses and movies.

Congress of International Society of Surgery
Mexico City, Mexico
October 27 - November 2, 1957

AMA PLANS SCHOOL HEALTH CONFERENCE THIS FALL

"A Decade of Progress in Fitness" will be the theme of the sixth National Conference on Physicians and Schools to be held October 30 to November 2 at the Moraine-on-the-Lake Hotel, Highland Park, Illinois. Sponsored by the AMA's Bureau of Health Education, this year's program will emphasize a continuing interest in the health and all around fitness of children and youth.

Pan American Congress of Endocrinology
Buenos Aires, Argentina
November 3-9, 1957

Hotel Statler, Boston
November 5-7, 1957
This year's program
With Emphasis on the Practical-Will Feature

\$200,000 worth of tests each year assure the quality of Hood Milk

No wonder Hood Milk is the finest in New England! The Hood quality control system — which costs \$200,000.00 annually for laboratory tests alone — is by far the most comprehensive in New England . . . and probably in the country. Dairy and public health experts from all over the world visit Hood installations . . . study Hood procedures . . . endeavor to equal Hood achievements in purity, flavor and richness.

Quality control as practiced by Hood begins with the selection of the supplying farms, follows the milk every step of the way to the customer's door. Each batch of Hood milk is tested 33 times before it's placed in the Hood trucks for delivery to homes, stores and institutions. Bacteriological tests alone number 750,000 each year. Thus, even in New England, where state and local laws set very high standards of performance . . . Hood Milk *consistently exceeds all legal standards* for purity and richness . . . consistently provides New Englanders with world-famous health protection.

*The name you
know you can trust*



AROUND THE STATE

Medical Specialists—Payment By the State

1. For purposes of payment by the State, specialists are presently defined as doctors of medicine who are diplomates of one of the American Boards of Medical Specialties, or who meet the criteria of the Connecticut State Medical Society expressed in paragraph 4 below.

2. The names of all diplomates practicing in Connecticut, as published by the Advisory Board for Medical Specialties in the Directory of Medical Specialists, latest edition, will appear on the State's specialist list.

3. Doctors of medicine who have achieved diplomate status since issue of the most recent Directory, and those who have met the State Medical Society's criteria as noted in the following paragraph, if they wish listing as specialists by the State should so write the Commissioner of Finance and Control, State Capital, Hartford, Connecticut, giving their qualifications.

4. The criteria applied by the Connecticut State Medical Society are: (1) is the physician a diplomate of one of the American Boards of Medical Specialties? (2) is he eligible for admission to examination given by one of these Boards? (3) is he a fellow of one of the recognized colleges composed of doctors of medicine, such as the American College of Surgeons or the American College of Physicians? (4) is he recognized by his fellow physicians in his own community as a specialist in a particular field of medicine, as evidenced by holding a position of importance on the staff of a hospital?

5. For necessary specialist services to State beneficiaries, specialist fees as listed in the Practitioners Fee Schedule issued by the Commissioner of Finance and Control will be paid to those physicians, only, whose names appear on the State's list of specialists.

Connecticut Regional Blood Program

The first new civilian demand on the Connecticut Blood Program since its start in 1950 is about to occur. It is probable that sometime this year open-heart surgery will be done in this State. Not only is it therefore necessary to collect 80,000 pints of blood

for the normal use of our hospitals, but it also will be necessary to collect additional blood—which must be fresh for open-heart surgery—at the rate of fifteen to twenty pints for each operation. If the experience of other Centers, such as Boston, Cleveland or Philadelphia, is any indication, it would appear that this program is faced with a job of supplying five thousand additional pints annually from donors selected by type.

The medical profession can help this program greatly by explaining to families of heart patients, both the need of accurate and intensive cross matching of blood, which will require a visit to the hospital laboratory approximately one week prior to open-heart operations, and the need for drawing fresh blood at the time of the operation. It is felt at the beginning the spectacular nature of such an operation will readily attract donors; but again, experience has shown that after the initial attraction donors can be secured only by organization and hard work.

If you have in your practice patients that are likely to undergo such surgery, careful explanation of these needs to the families will help this program in the procurement of blood and prevent the postponement of operations due to lack of suitable blood. The medical director of the Blood Center, in Hartford, will be glad to furnish any available information upon request.

DONORS		JULY 1957
Donors accepted	6,805	
Donors rejected	644	
Donors registered	7,449	
BLOOD ISSUED TO HOSPITALS		
To Connecticut hospitals from Center.....	6,404	
Blood collected by hospitals.....	446	
To fractionation stock pile.....	153	
To out of State hospitals.....	12	
		7,015
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	98	
Processed into packed cells.....	0	
Processed into liquid plasma.....	855	
		953

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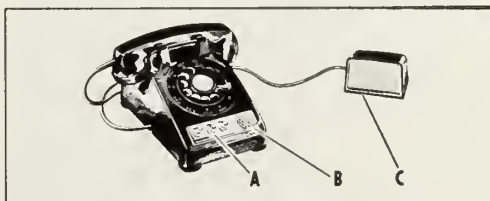


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Discarded—unfit and broken.....	55
Grand Total—distribution of blood.....	8,023
Blood returned to center for processing into plasma and fractions	917

BLOOD DERIVATIVES ISSUED TO HOSPITALS

Irradiated plasma (300 cc.).....	38
Fresh frozen plasma (125 cc.).....	187
Serum albumin (100 cc.).....	115
Immune serum globulin (2 cc.).....	0
Packed red cells.....	0
Fibrinogen	0

Dr. Weadon Honored

William Lee Weadon, who recently retired from active practice after 52 years, was honored by a testimonial dinner given by the members of the surgical and medical staffs of St. Vincent and Bridgeport Hospitals at the Brooklawn Country Club, Bridgeport, on July 16. Dr. Weadon who is now 75 years old, besides being a prominent surgeon, has been an avid golfer. He is a native of Virginia and came to Bridgeport in 1912.

Doctors Elected to British Society

Four Connecticut doctors have been elected members of the Royal Society of Health of London, England. They are as follows: Herbert R. Edwards, associate professor of public health and medicine at Yale University; Morris Granoff of New Haven; George B. Darling, professor of human ecology at Yale University; Willard A. Krehl, associate professor of nutrition, Yale University.

New State Commission on Tuberculosis and Chronic Illness

Three physicians have been appointed by Governor Ribicoff to the new seven member Commission on Tuberculosis and Chronic Illness. From Wallingford is Sterling B. Brinkley and from Hartford James R. Miller and John Allen. The new commission replaces the old State Tuberculosis Commission and the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm.

School of Veterinary Medicine Planned for University of Connecticut

New England will have a school of veterinary medicine when present plans at the University of

Connecticut are fulfilled, according to President Albert N. Jorgensen. The Connecticut legislature has appropriated funds for developing plans and specifications for a site which has already been selected at Storrs.

The new school will be constructed in close relationship to a new life science building for which \$3,650,000 has been appropriated, and the new physical science building costing \$3,250,000. Also available will be the facilities of the recently completed animal industry building, the animal pathology building and a poultry science building which is now under construction.

Leaders in agriculture, business, public health and education have long been concerned because no facility has been available in the region, and New England students have had increasing difficulty in gaining admission to the 17 accredited schools in this country.

Private Duty Nurses Raise Fees

The members of the Private Duty Nurse Section of the Connecticut State Nurses' Association have voted to set \$16 as a recommended statewide minimum fee for eight hours of nursing care. This became effective on July 17, 1957.

An additional fee of \$1 over the day rate for an eight hour period may be charged for patients with serious mental disturbances, communicable disease or acute alcoholism. When services are rendered to two patients in the same home or institution the fee is \$12 for each patient or a total of \$24.

It also was voted by the group to present bills after five days, or as may be agreed upon by the patient or his designated agent and the nurse.

At this present time nurses in one area are receiving \$17 for an eight hour period, and nurses in seven cities, representing eleven registries, are receiving the \$16.

It has been estimated by the CSNA that \$16 is equivalent to the recommended \$1.70 an hour for the general duty nurse in addition to paid vacation, holidays, sick leave, low cost hospitalization, medical and surgical care plans, shared social security, annual increments in salary and other benefits, premium pay for evening and night nursing, and sometimes other desirable benefits as retirement plans, credit unions, low cost life insurance. Nor does the general duty nurse pay a registry fee.

Current Concepts in

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The adequately balanced diet must contain carbohydrate as an essential nutrient. Though some carbohydrate becomes available to the body from the transformation of protein and fat, these sources contribute minor amounts of the total carbohydrate requirement.

Body energy comes from the oxidation of carbohydrate and fat but carbohydrates are oxidized preferentially. The brain derives its supply of energy exclusively from the oxidation of carbohydrate. Besides, the infant's requirement for energy is unusually high and can be most readily satisfied by carbohydrate.

All tissues of the body constantly require and use carbohydrate under all conditions. Even a temporary fall of the blood sugar below critical levels is accompanied by serious disability. However, the amount of carbohydrate in the body at one time is very small. It would sustain life for only a fraction of a day. Consequently, the infant must be offered carbohydrate frequently to yield a generous proportion, usually over half, of the total caloric intake.

The breast-fed infant receives about 12 gms. of carbohydrate per kilo body weight, while the artificially fed infant receives about 8 to 14 gms. per kilo. In the choice of an added carbohydrate, we must consider adaptability, tolerance, digestability, absorption, fermentability, and irritation to the intestines.

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3	675		
4	725	110	50
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7	825	100	45
8	850		
9	875		
10	900	95	43
11	950		
12	1000		
24	1200	90	40



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State CD to Lose Dr. Keeler

William H. Keeler, M.D., director, Medical and Health Services, State Office of Civil Defense, since March, 1956 is leaving his post to do graduate work at Yale University this fall. During Keeler's tenure, integration of disaster planning was achieved between the State Office of Civil Defense, the Connecticut State Department of Health, and the American Red Cross with regard to medical and health services.

Another accomplishment was the organization of a health services advisory council to handle top policy items at the State level. In addition to the Connecticut Hospital Association the following agencies are represented on this council: State Department of Agriculture, State Food and Drug Commission, Connecticut State Dental Association, Connecticut State Medical Society, Connecticut State Department of Health, Connecticut Pharmaceutical Association, Connecticut Funeral Directors Association, State Bureau of Public Health Nursing, American National Red Cross, Connecticut Regional Blood Program, State Department of Mental Health, Connecticut Osteopathic Society.

CHA has been most enthusiastic about this development for in November, 1955 its Committee on Disaster Planning reported: "Hospitals should participate with other community leaders in planning for natural as well as war caused disasters and should be represented at the highest level in State, local and regional disaster planning."

American College of Chest Physicians

Fred F. Tirella of Bristol received his certificate of Fellowship in the American College of Chest Physicians at the Convocation in New York City on June 1.

Arnold B. Rilance of New Haven was elected Governor of the College for Connecticut.

Hartford County

Speaking at one of the Hartford Hospital clinics was Charles McLean, chief of the hospital's cardiopulmonary laboratory. His topic was "New Approaches to the Diagnosis of Heart Disease."

Transferring from Tolland County Medical Association to HCMA is Deal T. Aseltine.

Chosen to serve as acting director of the Commission on the Chronically Ill, Aged and Infirm is

Elizabeth Cornfield of New Britain. A member of the Commission since the fall of 1954, she has been research consultant, active in the study of the aged in mental hospitals. Dr. Cornfield succeeds Dr. Sidney Shindell of Rocky Hill, who has resigned as director. A native of Ansonia, Dr. Cornfield is a member of the board of directors of the New Britain-Berlin Area Tuberculosis Association. She holds degrees from Albertus Magnus College, the Woman's Medical College and Yale University School of Public Health. She is the wife of Dr. Harry Bellach.

New special committee on insurance for HCMA is composed of Samuel Cohn, chairman, Stevens J. Martin and Edward Truex.

Jessie E. Parkinson will assist Schuyler G. Kohl, associate professor of obstetrics and gynecology at the State University of New York's College of Medicine, in the new obstetrical study in Hartford County. Dr. Parkinson was formerly with the Connecticut State Department of Health.

The Greater Hartford Tuberculosis and Public Health Society has announced that it will set aside \$300 to be used by Greater Hartford physicians to attend refresher courses, postgraduate courses, clinical conferences and meetings on chest diseases. You may apply by calling the Society's office at CHapel 6-2555.

Elected president of the Greater Hartford Association for Mental Health is Frank R. L. Egloff of West Hartford.

Rocco J. Romaniello of Hartford was recently named chief of staff for the West Hartford drum corps parade. The parade was part of a drum corps competition for all State units.

Appointment of Charles P. LeRoy, Jr. as medical director of the Employee Health Division, medical department of the Travelers Insurance Companies, has been announced by R. M. Filson, chief medical director.

DR. CAVEN TO MENTAL HYGIENE POST

Hugh J. Caven of West Hartford, a member of the JOURNAL Editorial Board, has received the appointment as director of the Bureau of Mental Hygiene, State Department of Health. Dr. Caven was formerly on the staff at the Institute of Living. He is certified by the American Board of Psychiatry and is a member of his county, state and national medical societies as well as the Hartford Psychiatry Society.

Middlesex County

Iain Todd finished his internship at the Middlesex Memorial Hospital and has gone to the medical school in Toronto to work on a research problem on fat embolism. Following this he will have a residency in orthopedics there.

New Haven County

Louis A. Notkins of New Haven died July 21 at Gaylord Farm, Wallingford. Dr. Notkins had practiced general medicine and neurology in the New Haven area for 53 years.

John H. Bumstead, prominent New Haven specialist in internal medicine, died suddenly on July 29 while visiting at Grace-New Haven Community Hospital. Dr. Bumstead served on active duty in both World Wars. For over 20 years he was associate clinical professor of medicine at Yale University School of Medicine and a member of the University's Health Department.

Windham County

At the Woman's Auxiliary Night of the Eastern Section meeting of the International College of Surgeons held at Dixville Notch, New Hampshire in July, Sidney Vernon of Willimantic spoke on "Experiences of a Surgeon on Bataan."

FELLOWSHIPS FOR CONNECTICUT PHYSICIANS

Recent action by the General Assembly and Congress has provided funds for graduate study in public health by physicians in Connecticut. The fellowships cover cost of tuition for graduate study at Yale, Harvard, Columbia, Johns Hopkins, Michigan and other universities with accredited schools of public health, and in addition carry a stipend averaging \$400 per month based on the individual applicant's circumstances.

Interested Connecticut physicians are urged to communicate at once with Henry P. Talbot, M.D., Connecticut State Department of Health, Hartford (Telephone JACKson 7-6341, Ext. 833) so that qualified applicants can complete plans for university entrance at the beginning of the term in September, 1957.

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Internist certified, 31; family, completing military service, January 1958; teaching hospital trained; interested in clinical medicine and cardiology; seeks group, solo, associateship, partnership, or permanent job; no rural, small town, or general practice. Write to: A.W.P. c/o Connecticut State Medical Journal, 160 St. Ronan Street, New Haven 11, Connecticut.

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NEW BOOKS IN REVIEW

THE RIDDLE OF STUTTERING. By C. S. Bluemel,
M.D. Danville, Illinois: The Interstate Publishing Co.
1957. 142 pp. \$3.50 (clothbound), \$1.50 (paper bound).

Reviewed by GEORGE F. MAIL.

Authorities estimate that there are over a million stutters in the United States. A recent survey of New England children found that roughly one per cent of them are handicapped with stuttering. This is a disorder which brings a great deal of suffering upon the patient, affecting as it does verbal communication with people—part of the bone and marrow of human existence. The havoc ranges from the practical matters of difficulty in talking with the store clerk and of interference in one's capacity to earn a living, to the fundamental one of hindering the development of intimate human relationships.

Bluemel brings a long life of experience to bear on this problem. Over 40 years have intervened between his first and this latest book on stuttering. His present short book is a statement of his ideas growing out of his clinical experience. This is reflected in the fact that, aside from a purely historical bibliography, there are only some two dozen references cited in the body of the book proper. There are only three references to the psychiatric literature and none of these pertain specifically to stuttering.

To understand Bluemel's theory of stuttering one must conceive of two simultaneous processes in speaking—an inner, silent speech and the outer, audible speech. In the etiology, as well as the continuation of stuttering, one of the critical factors is momentary blocking or muting of the inner, silent speech. It is Bluemel's thesis that this type of primary mental block, accompanied by emotional excitement, results in the primary stuttering of childhood. Primary stuttering consists of such utterances as "m . . m . . milk" or "m . . ilk." Bluemel continues that children whose speech and personality are "poorly organized" are severely traumatized when they hear themselves speak in this manner. They then suffer further excitement and anxiety, further primary mutism in their inner speech, and further external stuttering. At the same time the child now struggles forcefully to say correctly the disfigured words. This effort phase is secondary stuttering. It comprises all the overt signs of stuttering that the listener perceives in the habitual child and adult stutterer. Further complications arise. With repeated experiences of primary and secondary stuttering, the individual develops specific word phobias, and obsessive fears about specific speaking situations and talking in general. These increase the degree of disorganization of inner speech.

The most novel of Bluemel's ideas concern treatment. His therapy is directed principally towards developing "well organized" inner speech or organized thought—the lack of which he believes to be an essential etiological factor. His therapy does this in part by having the stutterer listen repeatedly to good models of organized speech as are provided in special prepared phonograph records. An especially interesting coordinated step in treatment is to train the stutterer to engage in silent, inner speech. In doing so he comes

to experience, and thus recognize, fluency as well as as the primary mental blocks. As his fluency in silent speech develops, the stutterer is then gradually led into trying out fluent, audible speech itself. Bluemel recommends that for best results all treatment be carried out in classes, rather than individually.

Bluemel has written more in the conversational style than in the academic tradition. This has the advantage of a certain freshness and spontaneity of expression. He has seasoned the book liberally with brief thumb-nail clinical examples. But the style also lends itself to a certain amount of repetitiveness, loose organization and dogmatic assertion.

There are two major deficiencies in the book. First, there is nowhere a serious attempt to unravel the psychodynamics of the stutterer, the meaning of the speech symptoms or the problems of psychotherapy with stutterers. This is all the more surprising when Bluemel states in closing that: "Despite some sterile areas in the psychiatric concepts of stammering, the real progress of the present century seems to be the wide acceptance of the speech disorder as an emotional disturbance, or psychoneurotic disorder, rather than a speech impediment" (p. 133). It is apparent, however, that Bluemel grasps and practices, perhaps intuitively, many important psychodynamic principles. This was especially clear in his recommendations on the handling of children. Secondly, Bluemel presents no data whatever on the effectiveness of his treatment method.

SCIENCE LOOKS AT SMOKING. By Eric Northrup. Introduction by Dr. Harry S. N. Greene, chairman, Department of Pathology, Yale University. New York: Coward-McCann, Inc. 1957. 190 pp. \$3.

Reviewed by STANLEY B. WEID

If you are a cigarette smoker and are confused by the conflicting statements of Dr. Alton Ochsner, the late Dr. Evarts A. Graham, releases by the American Cancer Society, and finally by Dr. Clarence C. Little's recent statement before the Subcommittee on Legal and Monetary Affairs of the House Committee on Government Operations, you will do well to read Eric Northrup's review of the entire problem of the relationship of cigarettes to lung cancer and to coronary heart disease. In this volume you will find a discussion of cancer as a disease and of lung cancer in particular, of the attributed relationship between cigarette smoking and heart disease, the known effects of the properties of tobacco, a summary of animal experimentation in the quest for the cause of cancer, and an appraisal of statistical evidence incriminating cigarettes as brought out in the famous Hammond-Horn study.

Dr. Greene's introduction is particularly critical of conclusions reached by the proponents of the group who claim a definite relationship between the increased consumption of cigarettes and the rising incidence of lung cancer. His most telling argument would seem to be the lack of diagnosis based on actual autopsy findings. When he says "I will still continue to smoke, and if the tobacco companies cease manufacturing their products, I will revert to sweet fern and grape leaves," he weakens his position as an unbiased scientist.

The two final chapters of this volume by Eric Northrup sum up in a masterful manner the basic confusion and incon-

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clusiveness surrounding the question of smoking and human health. He points out very wisely how far we are from possessing sufficient data to enable our most analytical investigators to reach definite conclusions in this controversy. He emphasizes the many factors involved, such as individual susceptibilities, the unknown etiology of cancer, the various ingredients in tobacco products, and the effects of different environments. He closes with these pertinent words: "Living, after all, is a series of calculated risks, not least of which is the risk of falling for medical statistics. To yield small pleasures without protest is a thoughtless waste. Life, at best, is a losing proposition. As Mark Twain put it, nobody ever came out of it alive."

RYPINS' MEDICAL LICENSURE EXAMINATIONS.

Edited by *Walter L. Bierring, M.D.* Topical Summaries and Questions. 8th Edition. *Philadelphia and Montreal: J. B. Lippincott Co.* 964 pp. 1957. \$10.

Reviewed by *LOUIS P. HASTINGS*

This book continues to be a review in preparation for licensing examinations by maintaining the original plan of presenting a concise and orderly synopsis of the various fields of medicine. A recent and timely addition is a complete rewrite of the opening article on medical qualifying examinations with explanation and useful examples of the multiple-choice, objective form of examination. This type of test has already proven its superiority over essay forms but is unfamiliar to the foreign graduate. It is regrettable that more examples of such questions are not given in each section as is done under public health.

We agree with the original author that examining authorities should be chiefly interested in inquiring into the ability of the candidate to apply knowledge of the basic sciences clinically. Despite this, Part I of the book presents its material on basic science without much attempt at application. The section on biochemistry is the best in this respect but the reviewer must, with honesty, note that pathology is presented with little or no clinical approach nor with modern functional flavor. This tendency appears to be the major weakness in an otherwise excellent volume. Part II, dealing with clinical subjects, is well done and should be valuable to the prospective examinee. The modern concept which stresses that the infant is not merely a small adult suggests that a section on pediatrics would be an extremely valuable addition to the next edition of this, one of the better books for its purpose.

HARTFORD COUNTY MEDICAL ASSOCIATION SEMI-ANNUAL MEETING

HARTFORD, TUESDAY, SEPTEMBER 24

HOTEL BOND, HARTFORD

Speakers:

Mr. Charles Zimmerman, President, Connecticut Mutual Life Insurance Company;
Mr. William Fenniman, Vice President, Connecticut Bank and Trust Company;
Mr. E. H. Heilman, Jr. of the accounting firm of Knust, Everett and Cambria, and
Mr. John H. Reige of the law firm of Reid and Reige

Subject: THE FINANCIAL AND LEGAL PHASES OF MEDICAL PRACTICE

The CONNECTICUT STATE MEDICAL JOURNAL

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No. 10

COMMON ERRORS IN THE DIAGNOSIS OF THE ACUTE ABDOMEN

SAMUEL J. STABINS, M.D., *Rochester, N. Y.*

It is important to remember that not only do common errors exist, but that those errors are common to us all. That to a certain degree these errors will continue to exist there can be no doubt. However, if one can determine the reasons for such errors, the possibility of reducing the incidence becomes more promising. It was in this spirit that I undertook a review of the more common conditions of the acute abdomen that had been admitted and treated at the Genesee Hospital, Rochester, New York, over varying periods of years. The Genesee Hospital is a two hundred and fifty bed voluntary community hospital affiliated with the University of Rochester School of Medicine and Dentistry within the past twelve years.

Of some significance was the failure to evaluate the total individual. Even more significant was the failure to observe the patient long enough for localization of the pain. To both of these errors, to a certain degree, I believe we have all contributed. Since in acute abdominal disorders pain primarily is responsible for bringing the patient and doctor together, it represents the first possible chance for error. By a careful and thorough history the observer, even before he begins his physical examination, may well have evaluated the importance of the pain described by totally evaluating the patient describing it. If the history and nature of each patient's pain are carefully analyzed the physician may be able to distinguish deep from superficial pain, referred from local pain, thus leading to the source of the pain. When we can pinpoint the exact seat of pain we have made an important step towards obtaining a correct diagnosis. This is no easy matter for pain which arises in the abdomen and pelvis may be somatic or visceral, or both, in origin. When a patient is suffering from pain in any part he instinctively is inclined to believe that he must be

The Author, *Associate Professor of Surgery, University of Rochester School of Medicine and Dentistry, Surgeon in Chief Emeritus, Genesee Hospital, Rochester, N. Y.*

SUMMARY

The first common error in the diagnosis of the acute abdomen is the failure to locate the seat of the pain experienced by the patient. Use of wrong methods in the examination may result in further errors. There are several important laboratory aids, all listed by the author, which should be used only as adjuncts to the clinical evaluation.

The most common error is the underdiagnosis or overtreatment and the overdiagnosis and the undertreatment of acute appendicitis. In the upper abdomen errors frequently occur in the diagnosis of acute cholecystitis, acute pancreatitis, perforated ulcer, and acute diseases of the chest. Errors occur fairly frequently in the diagnosis of dissecting aneurysm of the abdominal aorta and infrequently in small bowel obstruction. Errors in the diagnosis of closed abdominal trauma many times lead to fatalities. Several procedures are listed which should be followed to prevent common errors in the diagnosis of abdominal injuries due to closed blunt trauma. Five necessary measures are suggested to prevent errors in the diagnosis of acute abdominal conditions.

suffering from inflammation in that part. Pain, however, is not in itself an indication of an inflammatory state. The true sign of any local inflammatory condition is an increase in temperature or heat. When pain in any part is not associated with this increase in temperature or heat locally, it must be regarded as sympathetic pain caused by an abnormal sensitivity of nerves of the part and it is to be regarded

as a pain depending on a cause situated remotely from the part where it is felt. If a patient complains of pain on the surface of the body, it must be expressed by the nerve which resides there. There is no other structure that can express it and somewhere in the course of its distribution between its peripheral termination and its central origin the precise cause of the pain expressed on the surface must be situated.

In appendicitis the typical pain is described at first as a midabdominal colicky pain transmitted over the splanchnic nerves during the period of distention and stretching of the appendiceal wall. Later as the inflammation spreads from the appendix to the more sensitive parietal peritoneum it elicits pain in the right lower quadrant over the distribution of the intercostal nerves. This represents a somatic pain produced by the inflammation of the peritoneum as a defense reaction to put the diseased part at rest. However, in retrocecal and intrapelvic appendicitis the parietal peritoneum in the right lower quadrant may not be stimulated and the localizing signs are absent. This has great clinical significance for most of the failures in the diagnosis of acute appendicitis are due to a failure to recognize the very great difference in symptoms and signs that result from the varying positions and relations of the appendix to its surrounding tissue.

Sir Thomas Lewis¹ has stated that a history of pain related with the full circumstances in which it is felt may itself be diagnostic of a given disease. As he so wisely stated, the description of the pain is most accurate at the time when it occurs and is often deliberately revised when it recurs. He concludes that a complete description of pain should comprise a statement of severity, duration, of kind or quality, of relation to time and of the locality, and the circumstances in which it is felt. Of all the qualities of pain the severity is least important for it cannot be measured and the degree of severity as expressed by each individual may be very misleading unless you know the total individual. The kind or quality of the pain as expressed is dependent to a great degree on how clearly the patient understands the examiner. For example, when one asks whether the pain is a burning or a boring pain, the patient often is not certain what such an experience is and endeavors to answer in the manner in which he believes it is either most pleasing or annoying to the doctor. The most important information is the localization of the pain and the circumstances in which it is felt.

In this the patient is most accurate if the doctor is present when he is experiencing it. He cannot only localize the pain for you, but he can tell you in which position he is most comfortable and vice versa. As the pain subsides he is much less accurate.

In the absence of hematemesis, nausea and vomiting contribute very little to the localization of acute abdominal disease. The absence of fever has been responsible for a delay in operation and this holds equally true for patients in whom the white blood count has not been elevated. In this present day of antibiotic therapy which influences the temperature swing and the leucocytic reaction, the incidence of errors will increase if too much attention is paid to these factors. There are, however some laboratory tests which are extremely important in the differential diagnosis of the acute abdomen and if used properly they will reduce the incidence of common errors appreciably. These tests will be referred to shortly.

The most important localizing sign is the seat of maximum tenderness and spasm. A common error in the examination of the patient is committed in approaching the seat of maximum pain at the beginning and not the end of the examination. This is particularly true in children. Failure to use the stethoscope in abdominal examinations has been a common error. Likewise failure to perform pelvic or rectal examinations has been responsible for many errors, particularly in the patients with pelvic appendicitis.

The use of laboratory aids in the differential diagnosis and localization of the disease needs further elaboration. I refer to the word "aids" advisedly, for unfortunately today too often these tests are not used as aids but as the primary bases for diagnosis. The clinical evaluation has become of less importance much too frequently. The most important tests in addition to the routine blood and urine examinations include the serum amylase test that should be performed on every patient with upper abdominal discomfort in suspected acute pancreatitis; the sedimentation rate, particularly in children in the differential diagnosis of acute rheumatic fever and appendicitis; the transaminase test in the differential diagnosis of myocardial infarction or hepatitis and acute cholecystitis; x-ray of the chest in the differential diagnosis of pneumonia and acute cholecystitis or even appendicitis; the electrocardiogram in the differential diagnosis of acute heart disease and acute cholecystitis. The x-ray may also furnish

valuable information concerning the site, nature and extent of the underlying process within the abdomen. Some of the common abnormalities demonstrated by x-ray include free air due to a rupture or perforation of a hollow viscus, mechanical, paralytic or vascular occlusive ileus, calculi in the biliary, urinary or pancreatic system, calcification of the abdominal aorta, air in the biliary tract and displacement of intra-abdominal organs. It is at once apparent from the foregoing that a working diagnosis must be made before such detailed tests can be undertaken.

Certainly the most common error is the underdiagnosis or overtreatment and the overdiagnosis or undertreatment of acute appendicitis. In a review of seven hundred and forty-three patients operated upon for acute appendicitis at the Genesee Hospital from 1952 through 1955 there were five hundred and seventy patients (76.8 per cent) in whom the pathological findings confirmed the clinical diagnosis. In one hundred and seventy-three patients (23.2 per cent) the pathological findings did not confirm the clinical diagnosis (Table I).

TABLE I
APPENDICITIS (743 CASES)

	1952	1953	1954	1955	TOTAL	PERCENT
Acute.....	115	135	136	122	508	68.5
Perforation	12	18	13	19	62	8.3
Normal	77	36	35	25	173	23.2
					743	100

There are several points of interest to be mentioned. The number of cases of acute appendicitis operated upon annually has changed very little. However, there has been a gradual increase in the number of perforations admitted to the hospital, whereas during the same period there has been a sharp decline in the number of patients being operated upon in whom a normal appendix has been removed. In reviewing the records it was noted that rarely had the attending physician ordered a laxative in a patient with an acute abdomen. When a laxative had been taken it was usually on the initiative of the patient or a member of the family. However, in its stead a new form of evil has presented itself. I refer to the use of antibiotics. With its use in acute abdominal disorders it has become more difficult to evaluate the degree of inflammation present and this has accounted for a delay in diagnosis in many instances. This has been particularly

true in children under the age of ten. In ninety-six patients (16.9 per cent) with acute appendicitis, fourteen (14.5 per cent) had perforated before admission to the hospital. If the sedimentation rate is to be helpful in the differential diagnosis it must be done early since the value should be within normal limits in the early signs of acute appendicitis. In general the sedimentation rate is increased in all acute general infections while in localized acute inflammatory conditions variations in the sedimentation rate depend on the nature and severity of the morbid process. Lesser and Goldberger² in a review of three thousand readings in 2,000 patients with all types of disorders found the sedimentation rate to be uniformly normal in acute appendicitis.

Of the five hundred seventy patients with acute appendicitis including perforations, ninety-six (16.9 per cent) were in children under the age of ten; four hundred nine (71.8 per cent) were in patients between the ages of ten and fifty years, and sixty-five (11.3 per cent) were in patients over fifty years of age. Perforations occurred in fourteen patients (14.5 per cent) under the age of ten, in twenty-five patients (6.1 per cent) between the ages of ten and fifty, and in twenty-three patients (35.4 per cent) over the age of fifty (Table II). The high incidence of perforations in the elderly patients is well known and presents a real challenge in diagnosis. The minimal signs and poor response to the inflammation resulting in normal or subnormal leucocytic reaction are probably the most common causes for error. Of the sixty-two patients with perforation, fourteen (22.6 per cent) occurred in children under ten years of age, twenty-five (40.3 per cent) between the ages of ten and fifty, and twenty-three (37.1 per cent) over the age of fifty (Table III).

TABLE II
APPENDICITIS INCLUDING PERFORATIONS (570 PATIENTS)

AGE (YEARS)	PATIENTS	PERCENT	PERFORATIONS	PERCENT
Up to 10.....	96	16.9	14	14.5
11-50	409	71.8	25	6.1
Over 50	65	11.3	23	35.4

TABLE III
PERFORATIONS (62 PATIENTS)

AGE (YEARS)	PATIENTS	PERCENT
Up to 10.....	14	22.6
11-50	25	40.3
Over 50	23	37.1

In thirty-six patients (58 per cent) with perforation the appendix was either intrapelvic or retrocecal. Collins³ in a review of 3,003 consecutive cases of acute appendicitis found 751 (25 per cent) to be retrocecal. Of these 751 cases, 142 (18.9 per cent) presented fairly classical symptoms and signs. Rigidity was absent in 397 patients (52.9 per cent) and rebound tenderness was absent in 243 patients (32.4 per cent). Of the 173 patients (23.2 per cent) operated upon in whom a normal appendix was removed, the initial pain was recorded as originating in the right lower quadrant in 115 patients (67 per cent).

Short⁴ in his article on abdominal pain in children concluded that when the pain originated in the right lower quadrant it was unlikely to be acute appendicitis. The more probable diagnosis was mesenteric adenitis. Under the age of five diarrhea was an uncommon symptom in appendicitis. This was equally true in the adult unless a complication of the acute process had developed. Failure to differentiate between diarrhea and spasm of the small intestine due to irritation of the ileum in acute appendicitis has been responsible for some of the errors. A careful history of the bowel disturbance will readily lead to this differentiation.

The dramatic drop in the incidence of normal appendices removed is due in the main to a more careful observation of the patient for localization of his complaints. Although for the most part it is the result of this, in no small way the activity of the tissue committee has exercised a steady influence. In a few instances this committee, it appears, has been responsible indirectly for unnecessary delay. Thieme⁵ in a study of 2,071 patients operated upon for acute appendicitis during the period of 1935-1951, found an overall error of 20.6 per cent. His comments on the problems of a tissue committee reviewing the diagnosis of acute appendicitis are pertinent to this overall problem.

The most common diseases responsible for the removal of a normal appendix were acute gastroenteritis, hemorrhage from an ovarian follicle, acute salpingitis, ureteral stone and mesenteric adenitis. There were three patients with regional ileitis; three with a perforated diverticulum of the cecum; two patients with a perforation of a sigmoid diverticulum, and two patients with carcinoma of the cecum. The most common error in the cases of acute gastroenteritis was the failure to observe the patient

in the hospital for any period of time. It was not uncommon for surgery to be performed within four hours of admission following a fleeting examination by the surgeon who accepted the admitting diagnosis of acute appendicitis with little hesitation. In none of the cases with hemorrhage from an ovarian follicle or when "mittelschmerz" was suspected had an abdominal or cul-de-sac paracentesis for blood been done. The sedimentation rate, important in the differential diagnosis of acute salpingitis, was never obtained. Failure to obtain flat abdominal films and intravenous pyelograms when indicated in patients with red blood cells in the urine was responsible for unnecessary explorations. In the three cases of regional ileitis the history obtained before operation related entirely to the present illness. In retrospect these patients had been aware of bowel disturbances, chronic in nature and intermittent in character. In the two patients with carcinoma of the cecum the low hemoglobin levels recorded should have aroused suspicion of a more serious underlying disease than appendicitis. Failure to do a hemoglobin determination in any patient with an acute abdomen is an error that must never be committed.

In discussing the common errors in the upper abdomen I am taking the liberty of grouping acute cholecystitis, acute pancreatitis, perforated ulcer and acute diseases of the chest together. In one hundred and ninety cases of acute cholecystitis, one hundred sixteen (61.1 per cent) had a temperature on admission to the hospital of less than 100 degrees Fahrenheit (Table IV). Sixty-seven (35.3 per cent) had a white blood count of less than 10,000 and in forty-three cases (28.2 per cent) the total polymorphonuclear count was less than 70 per cent (Table V). Pain was the only constant symptom (100 per cent) with vomiting in one hundred and one cases (53.2 per cent). Localized tenderness was present in one hundred seventy-seven cases (93.2 per cent). Localized spasm was noted in one hundred twenty-one cases (63.7 per cent). A mass was only recorded in thirty-one cases (16.3 per cent) (Table VI).

TABLE IV
ACUTE CHOLECYSTITIS—190 CASES
ADMISSION TEMPERATURE

TEMPERATURE	CASES	PERCENTAGE
100° F. —	116	61.1
100° F. +	74	38.9

TABLE V
ACUTE CHOLECYSTITIS—190 CASES
WHITE BLOOD COUNT AND DIFFERENTIAL SMEAR

	CASES	PERCENTAGE
Less than 10,000.....	67	35.3
Over 10,000	123	64.7
Less than 70 per cent polys.....	43	28.2
Over 70 per cent polys.....	110	71.8
Not recorded	37	19.5

TABLE VI
ACUTE CHOLECYSTITIS—190 CASES
CLINICAL FINDINGS

	CASES	PERCENTAGE
Pain	190	100.0
Vomiting	101	53.2
Tenderness	177	93.2
Spasm	121	63.7
Mass	31	16.3
Negative except for pain.....	13	6.8

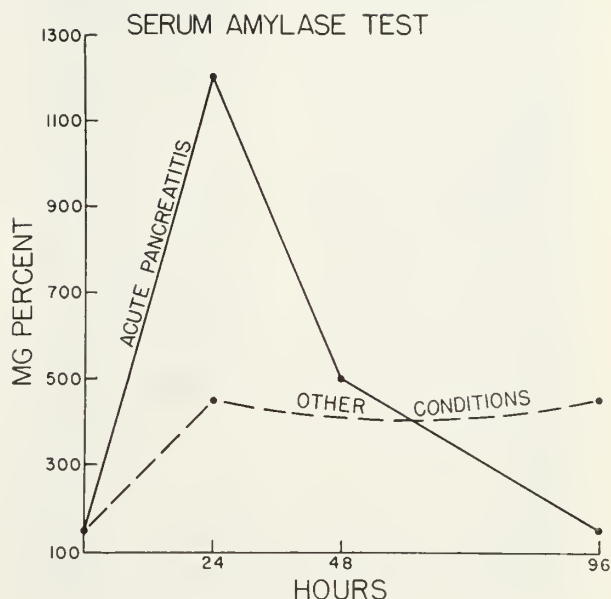
Vomiting was not an important symptom in the diagnosis of acute cholecystitis (53.2 per cent). The most important single factor was the localization of the tenderness. The most common error in the diagnosis of the acute gall bladder was failure to recognize that in 61.1 per cent of the patients the temperature was below 100° Fahrenheit and that in 35.3 per cent the white blood count was less than 10,000. With the increase in the use of antibiotics before admission to the hospital it is not unlikely that this error will increase.

ACUTE PANCREATITIS

There were fifty cases of acute pancreatitis reviewed in this study. No patient was under twenty years of age and one was over eighty years old. Of the fifty cases, 29 were in females and 21 in males. The serum amylase in every instance was greatly elevated and in almost every case within 18 to 24 hours the amylase had dropped back to half or less of its initial level. Within four days the serum amylase had returned to normal value in all patients who responded favorably. This curve is important to bear in mind in the differential diagnosis of other conditions with elevated serum pancreatic enzyme values without primary intrinsic pancreatic disease (Table VII).

Raffensberger⁶ reporting on twenty-one such cases noted that only one case had a serum amylase value

TABLE VII



over 400 mg. per cent (normal value 140 mg. per cent) and this was on the twelfth day of peritonitis following a ruptured appendix. Most of the cases were associated with a perforated ulcer, but none of the values dropped appreciably within the first twenty-four hours and in most instances the serum amylase rose gradually. A normal serum amylase level rules out acute pancreatitis, but in the presence of a low amylase reading, suspicion should be directed toward hepatic disease.⁷

The temperature and white blood count were of little diagnostic values and no correlation with the elevated serum amylase could be made out. To cite several examples, in one instance the serum amylase on admission was 1138 mg. per cent with a normal temperature and a white blood count of 4700. Within forty-eight hours the amylase had dropped to 66 mg. per cent. In another instance the serum amylase was 1040 mg. per cent with a temperature of 104 degrees and a white blood count of 7,300. Within seventy-two hours the amylase was down to 133 mg. per cent and the temperature was normal. Eight patients were subjected to operation. Of these eight patients, four were diagnosed as acute cholecystitis; two as acute pancreatitis; one as a perforated ulcer, and one as acute appendicitis. The patient with the preoperative diagnosis of perforated ulcer was operated upon shortly after admission despite an elevated serum amylase of 454 mg. per cent and negative

x-ray films for free air. The patient operated on with the admission diagnosis of acute appendicitis illustrates more graphically the error resulting from failure to observe the patient until the diagnostic tests put into motion have been recorded. A serum amylase was drawn before operation, but the report was not made available until after exploration had been performed. The serum amylase was 942 mg. per cent.

PERFORATED ULCER

In a review of two hundred and forty-nine cases of perforated ulcer it was found that in twenty patients (8 per cent) there was no ulcer history. Failure to obtain an ulcer history was responsible for some delay in arriving at a diagnosis. In one hundred and twenty patients (48.6 per cent) x-rays to visualize free air beneath the diaphragm were not taken (Table VIII). Today in all patients suspected of having an ulcer perforation it is a routine examination. Of the one hundred and twenty-eight patients (51.4 per cent) in whom x-rays were taken, a positive diagnosis was made in ninety-three (72.6 per cent). The most common error in this regard was the request for a flat abdominal film which is of no aid in the diagnosis. The incidence of free air was noted more frequently in the left lateral position rather than in the upright (Figure 1). It must be stressed that before the film is taken the patient should be in the proper position for at least three minutes. An error of not infrequent occurrence was that the diagnosis was not apparent until a previously sealed off perforation had reperfomed into the general abdominal cavity.

ACUTE DISEASES OF THE CHEST

In the past, basilar pneumonia and myocardial infarction were the most common causes for error in differential diagnosis. The x-ray, the electrocardiogram and more recently the transaminase determinations have made it possible to almost completely eliminate this error. Except for liver disease and particularly hepatitis, the transaminase determinations should not be elevated in acute abdominal diseases.

DISSECTING ANEURYSMS OF THE ABDOMINAL AORTA

There were thirty-two cases reviewed in this study. In nineteen patients (59.5 per cent) a flat abdominal film had not been obtained (Table IX).



FIGURE 1
Lateral decubitus film showing free air beneath the diaphragm

In the thirteen patients (40.5 per cent) in whom a flat abdominal film had been obtained, calcification of the abdominal aorta was noted in ten (76.9 per cent) to the degree that the roentgenologist reported the presence of an aortic aneurysm (Figure 2). In the presence of symptoms and signs of an acute abdomen the diagnosis of dissecting aneurysm became more apparent. Failure to obtain a flat ab-

TABLE VIII
PERFORATED ULCER (249 CASES)

	ULCER HISTORY NUMBER OF CASES	PER CENT OF TOTAL
Absent	20	8
Less than 1 year.....	178	71
Over 1 year.....	51	21
Total	249	100

X-RAY (249 CASES)

	CASES	PER CENT		CASES	PER CENT
X-rays	128	51.4	Positive	93	72.6
No x-rays	121	48.6	Negative	35	27.4
Total	249	100		128	100



FIGURE 2

Calcification of the abdominal aorta



FIGURE 3

Flat plate revealing air in the biliary tract secondary to gall stone perforation into small intestine

dominal film was the most common error in arriving at a diagnosis in these patients.

TABLE IX

DISSECTING ANEURYSMS ABDOMINAL AORTA (32 CASES)

CASES PER CENT			CASES PER CENT		
No x-ray	19	59.5	Calcification ..	10	76.9
X-ray	13	40.5	None seen	3	23.1

INTESTINAL OBSTRUCTION

Errors in the diagnosis of small bowel obstruction were not common. The classical clinical picture and the x-ray findings were usually quite obvious. Failure to take flat abdominal films was rarely noted. In three patients the diagnosis of small bowel obstruction was made by the presence of air in the biliary tract (Figure 3). Further study of the patients revealed a solitary gall stone in the small bowel as the cause of the obstruction. When errors did occur these were usually due to unrecognized incarcerated hernias in the inguinal or femoral canals. Large bowel obstruction likewise presented little difficulty in diagnosis. When the obstruction had gone on to involve the small bowel the diagnosis became more difficult. Barium enema studies when indicated will usually reveal the source of the obstruction (Figure 4).



FIGURE 4

Barium enema revealing obstruction at the splenic flexure. Film also presents evidence of small bowel involvement

DIVERTICULITIS OF THE LARGE INTESTINE

In twenty-one patients with perforation of the sigmoid admitted to the hospital, only two were operated upon for acute appendicitis. Jaundice is never an acute abdominal problem and is purposely omitted from this discussion.

Common errors are rarely committed in the diagnosis of bleeding from the gastrointestinal tract. The errors committed usually are in the management.

TABLE X
BLUNT ABDOMINAL TRAUMA (28 CASES)

	CASES	SURGERY	DEATHS	PER CENT	CONSERVATIVE	DEATHS	PER CENT
Spleen	19	15	2	13.3	4	4	100
Liver	3	1	0	0	2	2	100
Ileum	2	2	1	50	0		
Bladder	2	2	0	0	0		
Jejunum	1	1	1	100	0		
Pancreas	1	0	0	0	1	1	100

CLOSED ABDOMINAL TRAUMA

Penetrating abdominal wounds are obvious and usually present no real problem in diagnosis. The situation is quite different with closed abdominal trauma. In a review of twenty-eight patients with rupture of viscera, twenty-one were operated on with four deaths (19 per cent) (Table X). In the seven patients treated conservatively the mortality was one hundred per cent. The most common error was failure to recognize that multiple injuries may occur. The tendency to admit the patient on a specialty service, particularly the neurosurgical or orthopedic service, for an obvious head injury or fracture is a trend that must be curtailed if we are to salvage more patients. Every patient who has sustained a major injury must be observed by an attending physician or general surgeon. Failure to recognize this fact has been most embarrassing to the specialist and catastrophic to the patient. In patients with head injuries there were three who were admitted in an unconscious state on the neurosurgical service with a rupture of the spleen which was not recognized until the general surgeon had examined the patient many hours later. There were nineteen patients with rupture of the spleen. Abdominal paracentesis was done in only ten of the patients (Table XI). In nine patients (90 per cent) a positive diagnosis of intra-abdominal hemorrhage was made and laparotomy performed. In eight of the nineteen

patients (42.1 per cent) x-rays of the chest were taken for rib detail. In six of these eight patients (75 per cent) fracture of ribs of the lower left chest were found. In three patients with rupture of the liver, paracentesis was performed in one instance (33 1/3 per cent) and a positive diagnosis of intra-abdominal hemorrhage was made. Rupture of the bladder was made out in two patients by the simple introduction of a catheter. Failure to obtain urine and in its place a withdrawal of blood was sufficient evidence to warrant immediate operation. Perforation of the intestine presented the classical picture of a fulminating peritonitis. Flat abdominal films were taken routinely, but contributed very little. In one of the two patients with a perforation of the ileum a lateral decubitus film for free air was positive. If we are to avoid common errors in the diagnosis of abdominal injuries sustained by closed blunt trauma the following measures must be carried out:

TABLE XI
PARACENTESIS

	CASES	PARACENTESIS	POSITIVE	PER CENT
Spleen	19	10	9	90
Liver	3	1	1	100
Ileum	1	0		
Jejunum	1	0		
Pancreas	1	0		

(1) The patient must be under observation by a physician or general surgeon in addition to the specialist.

(2) Repeated blood studies, particularly the hematocrit and the white blood count, must be done. An initial hematocrit reading may be misleading because of hemoconcentration, and only after several readings can one be certain of its significance. The white blood count rises rapidly in intra-abdominal hemorrhage and it is not unusual to have a leucocytosis of 25,000 or higher shortly after injury.

(3) X-rays of the chest for rib detail should be ordered in all patients suspected of intra-abdominal injury.

(4) A lateral decubitus film should be taken on every patient suspected of gastrointestinal perforation.

(5) Intravenous pyelograms should be ordered in suspected injuries to the kidney or urinary tract.

(6) Abdominal paracentesis must be performed on every patient with evidence of intra-abdominal injury. The danger of bowel perforation in performing this procedure is theoretical and in the absence of bowel fixation is most unlikely.

(7) Routine catheterization should be carried out on any patient who cannot void shortly after an injury and on every patient who has been rendered unconscious.

CONCLUSIONS

In conclusion, it is my feeling that if we are to diminish the incidence of common errors in the diagnosis of the acute abdomen the following measures must be carried out:

- (1) The total individual must be evaluated.
- (2) A period of observation for the localization of symptoms and signs must be allowed.
- (3) The indiscriminate use of antibiotics must be curtailed.
- (4) The use of laboratory aids in the differential

diagnosis of acute abdominal disorders must not be overlooked.

(5) Patients with severe trauma must have in attendance a physician or general surgeon in addition to the specialist.

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THE DIAGNOSIS AND TREATMENT OF GOUT

JOHN H. TALBOT, M.D., *Buffalo, N. Y.*

The Author. Professor of Medicine, University of Buffalo School of Medicine, Buffalo, New York

SUMMARY

Selected aspects of the gouty dyscrasia are discussed. The malady is not a rare condition and should be suspected more often in general practice or in a specialty practice. The sudden onset of acute articular distress in a male in the middle decades of life should suggest gout. The clinical characteristics are helpful in the diagnosis as are the concentration of uric acid in the serum and the response to colchicine. The mechanism of the uric acid disturbance has not been revealed but most of the evidence suggests an increased formation of urate by body tissues. Colchicine remains the most useful drug in the alleviation of acute articular symptoms. Phenylbutazone and the adrenol steroids also have a place in therapy. The prophylactic regimen in the intercritical period embodies colchicine and Benemid daily. The patient is encouraged to pursue normal activities and eat a balanced diet save for the elimination of a few high purine substances. The combination of general and specific measures has been responsible for the thoroughly satisfactory management of this potentially seriously type of joint disease.

It is a pleasure to return to New Haven and to discuss with you a malady that is more amenable to alleviation of acute articular distress and correction, though temporary, of the underlying metabolic fault than any of the other common types of joint disease. Recent advances in the diagnosis as well as the treatment of gout, which have been a part of the tremendous new interest in all types of joint disorders, have focused attention once more upon this interesting metabolic malady. Although the internist is the one usually elected to establish the diagnosis of gouty arthritis and recommend treatment, the surgical specialist or subspecialist, as well as the general practitioner, should be familiar with the salient features of gout since the disease may appear unexpectedly in any physician's practice. Admittedly a number of physicians fail to appreciate the incidence of gout and gouty arthritis and unless they are gout conscious, are prone to label an unexplained acute articular episode as arthritis or infectious arthritis. There is also a lack of appreciation by some physicians of the proper handling of the dyscrasia once it has been suspected and the diagnosis confirmed. Except for the rare occurrence of specific infectious arthritis, gouty arthritis is the most satisfactory type of joint disease in treatment. The indications for therapy are clear, the drugs that are available are effective and symptomatic response is prompt.

DIAGNOSIS

The preliminary phase of diagnosis may precede the initial articular episode, particularly if one has insight into the potentialities of familial data and if the physician is interested in pursuing selected features of a past history. The family incidence of gout is a function of the interest of the physician

in accumulating familial data. A familial incidence as high as 80 per cent, and as low as 10 per cent, has been reported in the literature. In our series the incidence is somewhere between these values, i.e., slightly more than 50 per cent. The larger the number of male members of the family, the greater the probability of obtaining a positive family history. Sometimes a positive family history has been denied at the initial examination and the facts may

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From the Departments of Medicine, University of Buffalo School of Medicine and the Buffalo General Hospital, Buffalo, New York

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not be revealed until considerable delving into personal family matters is accomplished. The incidence of nonaffected relatives with an increased concentration of serum urate supports the familial nature of the malady. In a comprehensive study of sons and daughters, brothers and sisters and mothers and fathers of gouty patients, we discovered that one in five, without a past history of acute articular distress, revealed an increase in concentration of uric acid in the serum. The original observations were collected more than two decades ago. In the meantime we have continued to pursue the matter and believe that an increase in concentration of serum uric acid in the susceptible individual may well take place during adolescence.

Most important is the incidence of acute articular distress developing subsequently in such marked individuals. Also the question of prophylactic therapy for such persons should be considered. In our experience the incidence is negligible of acute gouty arthritis developing in nonaffected relatives who display an increased concentration of uric acid in the serum. Surely less than 10 per cent have developed an acute attack of gout over a period that in some relatives has been as long as 20 years. With this evidence we have not considered it imperative to begin prophylactic therapy merely because of an increased concentration of uric acid in the serum. The observation has been recorded and brought to the attention of either the individual under study, if an adult, or the parents if a child, and thereupon let the matter rest. In a few instances acute articular gout has developed at some later date and, when this occurs, the problem is handled as any other patient who may be observed at the time of the first attack of gouty arthritis.

There are several items in the past history that may precede the first articular episode. A renal stone is the most common. Since one in seven patients with gout will pass one or more renal stones during the natural history of the disease, it is not surprising that in some instances a stone is passed prior to the initial articular episode. There are a few instances in which stones were passed ten years or more before other evidence of gout was apparent. It is quite certain that if the serum uric acid had been determined at that time, an elevated value would have been observed. This serves to emphasize the need for the determination of the serum urate level in every patient who has passed a urate stone or possibly anyone who has passed a stone, irrespective of its

chemical nature. The mechanism of urate lithiasis will be discussed later. Albuminuria and an elevation of the blood pressure are other items that may be a part of the past history and precede joint symptoms.

The clinical characteristics of the acute attack of gouty arthritis are probably the most helpful criteria in suspecting or establishing a diagnosis. Sudden onset of acute distress in one of the peripheral joints of a male, especially in the middle decades of life, should point to gout as the first possibility. The cardinal signs of inflammation, redness, swelling, heat and tenderness, may be present with an elevation of body temperature as high as 103° F., a leukocytosis and an increase in the sedimentation rate. Characteristically the acute episode is associated with symptoms in the middle of the night, the patient having retired without any premonition of future events. The other common types of joint disease, i.e., acute rheumatic fever, acute rheumatoid arthritis and osteoarthritis are not associated with such acute distress although acute rheumatic fever may have rather severe joint pain. The larger joints of the body usually are afflicted in acute rheumatic fever and the migratory nature of the distress is characteristic. The metatarsophalangeal joint of the great toe is the classical joint involved in gouty arthritis and more than 50 per cent of the patients will experience acute distress in this joint during the acute bout. The bunion joint is exquisitely tender and street shoes cannot be worn with comfort. In some instances the leather of the shoe is split over the great toe, hence the designation "gouty shoe." In acute rheumatoid arthritis, systemic symptoms usually have been smoldering for weeks or months and the acuteness does not develop within a matter of a few hours. In rare instances a Heberden's node may be acute but this should offer little or no confusion in the differential diagnosis.

The mechanism of acute articular symptoms has not been revealed. Infiltration of joint structures by urates surely precedes articular symptoms. Once joint structures have been invaded the possibility of an acute attack is ever present. Increased precipitation of urate crystals preceding or during the acute attack has been postulated but not proven. The polyarticular nature of some of the severe bouts suggest that a systemic disturbance, rather than an exclusively local one, is responsible. Except for secondary changes usually attributed to inflamma-

tion about the joint, the physical appearance of articular tissue at the time of the acute attack is similar to that in the intercritical period.

ETIOLOGY OF ATTACKS

Precipitating agents that may be responsible for the acute attack should be discussed with the patient and appreciated by him. This is of great practical significance since recognition of such possibilities may enable the susceptible patient to begin treatment of the acute attack at a very early time. Overindulgence in food and alcohol occupy a rather prominent position in the older literature. In such instances it is believed that either one is related to the general insult to the body rather than because of any specific agent. The presumption that particular foods, except the high purine substances, are harmful to gouty patients is a prejudice rather than a substantiated observation. Even high purine foods sometimes fail to incite an acute attack and are not particularly reliable as a provocative agent in the diagnosis of the malady. There are a number of other agents that have a closer relationship. General or local physical trauma, an acute infection, minor or major, blood loss, emotional trauma and surgical operations may be noted. There are several drugs that should be withheld unless specifically indicated. Included are parenteral penicillin, ergotamine tartrate, vitamin B₁₂, mercurial diuretics and thiamine chloride.

The concentration of uric acid in the serum is of considerable help but the values should be interpreted carefully. The technical determination in the biochemical laboratory is not foolproof and unless the technician is thoroughly familiar with possible sources of error in the determination, a false or an equivocal value may be reported. It is important to appreciate that serum or plasma is preferred to whole blood because of interfering substances in red blood cells, substances that interfere with the development of color. The patient should abstain from the ingestion of any antirheumatic drug within a 48 hour period prior to the collection of the serum for the determination. Each of the nonspecific agents commonly used in the treatment of joint disease, such as salicylates, phenylbutazone and the adrenal steroids, result in an increased excretion of uric acid from the body, depress the concentration in the serum and may lead to a normal value in a patient with the gouty disturbance. Also, the uric acid may be elevated in normal persons for reasons not entirely clear.

This refers especially to some patients with rheumatoid arthritis. There is also a slightly lower range in females than in males. Most laboratories have established that the upper level for males is 5 mgm./100 ml. and the lower range for gouty males is 6 mgm. In females this range may be reduced by 0.5 mgm. If a patient with gout has a circulating concentration of 6.5 mgm./100 ml. of uric acid in the serum prior to the administration of an antirheumatic drug, it is likely that not more than 2 or 3 mgm. of salicylates will lower the value to 5.0 mgm. within a period of 24 to 36 hours. Under such circumstances the patient still has gout but the uric acid level is within the normal range. If strict adherence were paid to the urate concentration in such a circumstance, the diagnosis of gout might be rejected.

USE OF COLCHICINE

When the clinical features suggest acute gouty arthritis, it is unnecessary to wait for the interpretation of the x-rays of the affected joints or the laboratory to report the urate level. Specific treatment, i.e., colchicine, should be instituted without delay. This preparation is the only specific antiarthritic drug in the pharmacopeia, is indicated in gouty arthritis, and has no recognized action in the other types of joint disease. The response to colchicine, when given orally, may be extremely helpful in confirming the diagnosis, as well as therapeutically in alleviating joint distress. Colchicine should be ingested regularly, 1.0 mgm. every two hours until the onset of gastrointestinal distress, be it nausea, vomiting or diarrhea. Usually the side action is apparent after the ingestion of not more than 4 or 5 mgm. of colchicine. At this time colchicine ingestion is to be discontinued and a gastric sedative prescribed such as tincture of camphorated opium, 5 cc. every two hours so long as is necessary. The pharmacologic action of colchicine remains an enigma nor do we have any explanation as to the need for prescribing sufficient colchicine to produce gastrointestinal distress. The empiric observation is well documented, however, and it is necessary to insist upon ingestion at periodic intervals until the onset of nausea, vomiting or diarrhea, if the full anti-inflammatory affect of colchicine is achieved. This method of administration as described constitutes a "full course."

Roentgenographic findings in gouty arthritis have received considerable attention but usually are negative in the earlier years of articular distress. It is a

good policy to procure x-rays of the hands and feet as a matter of record but it would be exceptional if osseous tophi or cartilaginous changes were present early in the history of articular symptoms. After the disease has been apparent clinically for several years or more the characteristic punched-out areas in the epiphyseal portions of the joints, erosion of cartilage or diminution of joint space may be observed. It should also be noted that in some patients with well developed rheumatoid arthritis, cystic changes in the same areas of the hands or feet may be present. Rheumatoid arthritis usually is a diagnosis based upon clinical findings and the presence of a few punched-out areas of the bones suggestive of gout should not overrule the clinical presumption.

The presence of aural tophi should be investigated but the incidence is relative low. Subcutaneous tophi usually mean well developed gout with articular symptoms that have been present for a decade or more. The disease should have been recognized and brought under control before the development of subcutaneous tophi.

PATHOGENESIS

The pathogenesis of gouty arthritis is not clearly defined, but a considerable body of evidence supports one mechanism over the others. Uric acid is a naturally occurring substance in the body and is the end-product of purine metabolism. As noted above, the concentration of uric acid in the serum in a nongouty person varies between 3 and 5 mgm./100 ml. In the gouty subject, except for the administration of uricosuric agents, the range is 6 mgm. or higher. This increase above the normal is believed to be sufficient for the clinical manifestations of gouty arthritis and the development of complications in the gouty patient. The mechanism of the increased concentration has been attributed to impaired destruction by the body, a deficient excretion by the kidneys, or an increased formation by the tissues. The latter explanation is the favored one as meager evidence only has been produced in support of the first two possibilities. A number of patients with gout have normal renal function as determined by routine or precise laboratory procedures and in those with demonstrable renal disease, articular symptoms have been present for a number of years. It is believed, therefore, that the kidney is secondarily involved in the gouty dyscrasia and is not the organ to be incriminated originally. The concentration of the enzyme uricase in body tissues is suffi-

ciently low that it is believed that this mechanism is not operating.

There remains then the increased formation hypothesis with several observations in support of it. A few patients with gout will excrete from two to fourfold the quantity of uric acid in the urine over a normal nongouty person. This implies an increased formation of uric acid by the body. The nonaffected relatives with an increased concentration of serum urate may well have this trait in a moderate degree only. Finally, Stetten and associates have demonstrated a shunt mechanism whereby glycine is degraded to uric acid through a more direct pathway in some gouty subjects than in others. There are two other situations that may be analogous to hereditary gouty arthritis. In chickens and turkeys a high protein intake results in a noticeable increase in the serum and deposition of urate tophi in the joints of the extremities. Also there are several blood dyscrasias, notably myelofibrosis and chronic leukemia, conditions associated with an increased formation of uric acid in the body, which may show deposits of uric acid in a joint and suffer acute attacks of gout indistinguishable clinically from the hereditary dyscrasia. These several observations suggest that an increased formation of uric acid by the gouty person is the metabolic fault.

PROGNOSIS

The prognosis in this chronic malady is excellent save for the development of renal insufficiency. With the increased formation of uric acid by the body and the inevitable increased excretion by the kidney, chemical or mechanical insult appears inevitable. The degree of this insult varies, in some patients it becomes critical. Fortunately less than five per cent have died prematurely or will die prematurely because of the disease or this complication. Also when the kidney is severally insulted the course of the renal degeneration is an extremely slow one and a number of years may elapse between the detection of renal impairment and the development of critical renal insufficiency. More than 90 per cent of those afflicted with gout suffer surprisingly little if the prophylactic regimen, as noted below, is followed and they are able to lead normal lives if they wish. An occasional patient represents an exception to this optimistic statement. It is interesting that two of the three most difficult persons to manage in our series are physicians who refuse to follow either my medical advice or the advice of any other physician.

Having decided that they wish to be their own doctor, they have not fared as well as the vast majority of patients. On the other hand, there are several other doctors in the series who adhere to the simple schedule of management and do extremely well. It is surprising the number of physicians who are afflicted with this malady.

The majority of gouty patients who are cooperative and quite willing to follow the relatively simple prophylactic regimen, lead normal lives and pursue gainful occupations. An optimistic prognosis has been assumed since colchicine was recommended as a daily prophylactic a number of years ago. The future of gouty patients has been further enlightened by the discovery of Benemid more than seven years ago. Benemid, a potent uricosuric agent with an extremely low incidence of toxicity, has contributed to the thoroughly satisfactory management of the gouty patient. Once the blame for the acute articular episode is placed upon a disturbance of uric acid metabolism, treatment should be instituted at once. As noted above, colchicine is the drug of choice, particularly if the diagnosis has not been confirmed. Another reason for prescribing colchicine initially is to acquaint the patient with the various aspects of a "full course." It is true that colchicine is associated with gastrointestinal distress when full amounts are taken. Sometimes this is disturbing to the patient but is not a contraindication. In recent years we have modified the full course of colchicine to include supplementary phenylbutazone. If less than the full therapeutic amount of colchicine is taken, from 200 to 600 mgm. of phenylbutazone may be prescribed in addition for two or three days. There are some rheumatologists who prefer to use phenylbutazone exclusively for the management of the acute attack. In such circumstances from 400 to 800 mgm. of the preparation is prescribed daily for two or three days. We still rely largely upon colchicine alone and use supplementary amounts of phenylbutazone in selected instances only. The sole use of phenylbutazone is restricted to patients who have failed to begin the full course as soon as articular symptoms have developed or for some other reason, having responded inadequately to colchicine. If the acute attack has been present, untreated or poorly treated for one or more days, recovery may be partial only. If the joint distress, having been present for not more than 24 hours, does not respond to a full dose of colchicine, the diagnosis may be questioned or some

complication may be sought. During convalescence from acute gouty arthritis, early ambulation is to be encouraged. There are no other specific measures to be recommended for the treatment of the acute episode. General measures include an abundance of fluid, protection of affected joints, and a diet that suits the taste of the afflicted.

THE INTERCRITICAL PERIOD

The interval between attacks varies considerably. Several years may elapse in a person mildly afflicted. In some instances, one or two decades may separate the acute articular episodes. In the moderate or severely afflicted, however, frequency of attacks tends to be greater in spite of the absence of clinical evidence of chronic tophaceous gout. Patients who show gross deposition of urates in and about the joints of the extremities are prone to suffer greater incapacity from acute gouty arthritis per year unless prophylactic therapy is followed. Between the acute attacks, in patients without articular deformities, there are no subjective symptoms or objective findings.

The management of the intercritical period, although presented last in this discussion, is most important in the management of the patient with gout. Prevention of acute attacks should take precedence and if the prophylactic regimen is respected, acute attacks should be infrequent in incidence and the patient should be symptom free the vast majority of the time. Although the acute episode is a distressing affair, if allowed to reach full proportions, proper respect for prophylactic agents will reduce the incidence of acute attacks to clinical insignificance. The recommended prophylactic regimen is simple to follow, permits the patient to live a normal life and either stays or reverses the previously progressive effects of the disturbance of uric acid metabolism. In short, it is simple, satisfactory and effective.

SPECIFIC DRUG THERAPY

There are two drugs vital to the prophylactic regimen, colchicine and Benemid. There is no overlapping pharmacologic action; each drug complements the other; neither one by itself is as effective as the combination. The other antigout agents may be disregarded in prophylaxis if colchicine and Benemid are taken daily. Although little or no effect upon uric acid metabolism may be attributed to colchicine, the daily use of this preparation in the intercritical period has been found to be extremely

useful. It is a good practice for each patient to take some colchicine regularly. Originally this practice was followed without any adjuvant. In recent years, since Benemid has been available, this is the companion drug. The efficacy of the colchicine-Benemid regimen is convincing and the greater our experience, the more secure we are regarding therapeutic results and the low incidence of toxicity.

If the gouty affliction is mild and the past history reveals that the patient has suffered not more than one attack per year, one tablet of colchicine, 0.5 mgm., is recommended on each of three or more days per week. Patients moderately afflicted should take one or more colchicine tablets each day of the year. The severely afflicted should take colchicine up to the point of gastrointestinal tolerance daily. This may be two or three tablets, or in some instances, four tablets each 24 hours. The incidence of acute attacks was reduced significantly through the prophylactic use of colchicine alone prior to 1950. Since that time a further significant reduction in the incidence of acute attacks and an improved state of well-being has been reported. Tolerance does not develop to either drug and if an acute attack appears, a full course of colchicine is maximally effective, irrespective of previous prophylactic ingestion. Patients who have been on daily rations of colchicine for a decade or more receive the optimum benefit from a full course when this is prescribed. The number of patients who have taken colchicine daily for a decade or more is sufficiently large to state with assurance that such a regimen is beneficial and that if gastrointestinal symptoms are avoided during the intercritical period, the ingestion of colchicine daily is associated with no undesirable features. Another obvious gain in the ingestion of colchicine regularly is the advantage of having started a course at the earliest possible moment, should acute symptoms appear.

The addition of Benemid to the prophylactic regimen has provided a powerful uricosuric agent which results in an increased excretion of uric acid from the body and a concomitant increase in the concentration of uric acid in the serum. Initially we proceeded on the presumption that the larger the quantity of Benemid ingested, the greater the uricosuric action and the greater the inhibition of the tendency for urate precipitation in bony and soft tissues. Theoretically this still appears sound but our clinical experience has been satisfactory with slightly smaller doses. The average quantity for

patients moderately or mildly afflicted is 1 gm. of Benemid daily. The clinical benefit that accompanies the administration of Benemid and colchicine becomes increasingly more encouraging each year. If the level of uric acid in the serum is in the high gouty range, i.e., 8-12 mgm./100 ml., the ultimate level on Benemid averages 6.8 mgm./100 ml. If the uric acid disturbance is moderate only, i.e., 6-8 mgm. before Benemid, the normal range is reached subsequently.

It should be appreciated that our patients are encouraged to eat a balanced diet, drink an abundance of fluids and pursue any physical activity that suits his fancy. Only those items high in purine substances, such as liver, kidney, sweetbreads and anchovies are prohibited. The high fluid intake is necessary for providing additional fluid for the increased excretion of uric acid in the urine. Since the solubility of uric acid in the urine is near the upper limit of normal, an augmented uric acid excretion must have a similar increased amount of fluid available for transport. Alcoholic beverages are permitted. Our advice in this matter is for the patient to follow current mores, not old wives' prejudices. The increased excretion of uric acid in the urine following ingestion of Benemid persists as long as Benemid is ingested. Unfortunately, when the agent is stopped, experimentally or unintentionally, there is a prompt return to the pre-Benemid level with an increase and a reversion of the serum urate concentration. This does not mean that the benefits during Benemid therapy have been nullified but rather that the disturbance is chronic and with cessation of Benemid, the reaccumulation of urates in tissues begins anew.

The most important subjective evidence in support of the combination of Benemid and colchicine is the diminution in all patients and elimination in some of acute articular bouts. Acute attacks have appeared at times but they have adhered to the colchicine-Benemid regimen. Originally it was our impression that there was a slightly increased incidence during the first few weeks or months after beginning Benemid. This impression has not been confirmed subsequently. A number of patients have been on Benemid and colchicine for a period of seven years who had had a previous history of moderate or severe gouty arthritis and have not lost a day from work because of acute gout. A majority of our patients, irrespective of the severity of the disease, average less than one day per year of in-

capacity because of acute arthritis. Such a striking change from the incidence of attacks before beginning the combined therapy can be attributed justifiably to the addition of Benemid. It should be appreciated that Benemid is of no immediate value during the acute articular bout. When such an event occurs it is unimportant if Benemid is omitted for a day or so during acute symptoms, but should be resumed if discontinued at an earlier time.

The toxicity of Benemid is unimportant clinically. Bone marrow depression or liver damage, toxic actions of some of the other antirheumatic agents, has not been reported with Benemid. The incidence of renal stones is significant but has not increased with the use of combined agents. The desired pharmacologic action of Benemid, i.e., an increased excretion of uric acid in the urine, poses this potential threat but with an increased amount of available fluid, the solubility of uric acid in the urine should be unaltered. It is interesting to note that during the past seven years two patients have undergone major surgery because of a large urate calculus in the ureter. Each patient was on Benemid daily. During the preceding period with a considerably smaller number of patients in the series, the incidence of surgery for urinary stones was precisely the same. Benemid is a mild gastrointestinal irritant if taken in

full therapeutic amounts on an empty stomach. The distress may be prevented by the ingestion of Benemid with meals. A few patients have developed a skin rash but this has never become a serious clinical problem. One severe anaphylactic reaction has been reported in the literature. Desensitization was accomplished eventually, however, in this patient.

The length of time that a patient should be on Benemid daily has not been determined. It is our prediction that patients severely afflicted with gout will remain on Benemid and colchicine throughout the natural history of the disease. Those mildly afflicted are permitted considerable freedom. Patients with moderate gout may take Benemid from time to time, having been on it regularly for a minimum of two or three years, meanwhile maintaining one or two colchicine tablets daily. Since the escape from Benemid is rapid and return to the gouty range follows within a period from 24 to 36 hours after ingestion of the last Benemid tablet, a person moderately or severely afflicted should not remain off of Benemid for a long period of time, even though he may be clinically free of acute attacks. Since gout is a chronic disease the disturbance of uric acid metabolism persists so long as the patient lives. The threat of an acute attack remains with the increased formation of uric acid in body tissues.

RELATIONS BETWEEN MENTAL HEALTH AND PUBLIC HEALTH

JULES V. COLEMAN, M.D., *New Haven*

SINCE the passage of the National Mental Health Act in 1946, it has become customary to identify the mental illnesses as a public health problem, and therefore somehow related to the field of public health. A good deal of thought and effort has been devoted to the orienting of public health personnel to an awareness of psychiatric problems, concepts, and technics. The original stimulation for this kind of education of public health personnel came from the Commonwealth Fund, with its sponsorship of institutes on mental health for public health workers at Berkeley, California, in 1948 and at Biloxi, Mississippi, in 1949. There followed a spate of similar institutes in succeeding years in almost every section of the country sponsored by the Public Health Service, by state health departments, and by other state and local organizations. In 1953 the World Health Organization sponsored an institute of this kind in Amsterdam, attended by representatives of 15 European countries and the United States.

The major emphasis in all of these institutes might be recapitulated in the slogan "Public Health Is People,"* which formed the title of the book reporting the first institute at Berkeley. The central idea was that public health served large segments of the population in promoting health and in preventing disease and that it might make an important mental health contribution through its own services by incorporating psychiatric concepts and procedures in relation to such problems as the emotional components of illness, principles of child rearing, public education, public relations, health interviewing, and the intragroup tensions of the public health staff itself.

While these institutes helped to arouse the interest

The Author. *Clinical Professor of Psychiatry, Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut*

SUMMARY

For most of us the most pointed reminder of this discussion of mental health and public health relationships is this, "a psychiatric clinic cannot be expected to realize its value in a community that does not provide adequate basic health and welfare services."

of public health workers in the idea that psychiatry could offer them insights and skills that might enrich and deepen their services to people, there remained the practical problem of finding ways to implement the collaboration between psychiatry and public health at the level of personnel training. A variety of training programs, both in and out of the schools of public health, were gradually developed. Examples are the programs for the psychiatric orientation of pediatricians, the programs for the training of mental health nurse consultants, and the group dynamic approach in the training of health educators at the University of California. At the same time many public health departments all over the country were conducting systematic inservice training programs in mental health, both in the form of local institutes and in the use of consultants from the field of psychiatry.

The schools of public health began to experiment with the integration of psychiatric principles into their curricular teaching for all students. The problem of selection of appropriate content for this purpose, of methods of teaching psychiatric material, and of possibilities for sociopsychiatric research in a school of public health formed the agenda for a

*Ginsburg, Ethel L.: *Public Health Is People*. Cambridge, Mass.: Harvard University Press, for the Commonwealth Fund, 1950.

conference in 1952 at the Harvard School of Public Health. There was at least general agreement on one point: that psychiatric teaching should be incorporated as an organic aspect of the master of public health program of the school of public health. Since then all the schools that had not already done so have been experimenting with psychiatric teaching content, some with the addition of a psychiatrist as a full-time faculty member, others with psychiatrists employed as part-time lecturers. The use of the services of a mental health nurse consultant as a faculty member has also become fairly widespread practice. Here and there, the schools of public health have also added to their faculty personnel from such fields as social work, psychology, and sociology.

In all this activity, both in the schools and in departments of public health, the emphasis has been on the incorporation into the field of a new dimension of service rather than the development of new psychiatric subspecialties in public health medicine or public health nursing. For example, the position of the mental health nurse consultant has been regarded by many leaders in the field as transitional, as a device by which the public health nurse could develop sensitivity, awareness, and skill in the behavioral discipline. It is thought that the position will no longer be necessary when basic training in the field as a whole has reached the point where every graduate of a master of public health program has received adequate psychiatric orientation. A parallel may be drawn with training in schools of social work, where the subspecialty of psychiatric social work has been replaced by so-called generic training, i.e., with every social work student receiving the core content in psychiatry which was at one time reserved for the student of psychiatric social work.

At this moment, then, it may be said that public health is making rapid strides in the direction of implementing the notion that "public health is people." Public health personnel are becoming increasingly aware of the human factor in their program activities, whether in a well baby clinic, a school health program, a fluoridation proposal, a program of nutritional education, or a mass x-ray survey. They recognize the role of individual motivation in seeking and using health services and the extent to which motivation is influenced by personality dynamics, by family interaction, and by forces in the large variety of subcultures in our country. They also recognize that the anxieties associated

with physical illness and the threat of illness are important foci of disturbance of the climate of mental health in any community, and that anticipatory, educational, and administrative measures may be established by public health departments in dealing with such anxieties.

Public health, however, is also looking beyond the enrichment of its traditional activities by psychiatric insights to the problem of the more specific contribution it may make to the field of community mental health, i.e., of the treatment and prevention of mental illness and personality disorder and disturbance in the community. Here the problem is infinitely more complicated, if only because of the difficulty of identifying and demarcating areas of activity that properly belong to the field of public health. It would seem apparent that public health is not interested in creating new services which would duplicate or overlap existing programs in such fields as psychiatry, social work, psychology, or education. Rather the problem for public health is to discover in what way the lessons of its monumental achievements in the treatment and prevention of a wide range of physical illnesses may be applied in a new and constructive approach to the amelioration of psychiatric distress.

The means which public health can bring to this task are many and I shall discuss some of the concepts which have received attention in recent years. I should like to point out that many concepts that have proved fruitful in their application to the treatment, prevention, or control of physical illnesses are not always equally useful in a field like psychiatry. We know all too well that the major psychiatric illnesses, the functional neuroses and psychoses, are not discrete diagnostic entities in an organismic sense, but are rather products of an interaction in a state of constant flux between organism and environment, subject to steady pressures of modification, in a fluctuating balance in which spontaneous reparative processes are constantly seeking to assert themselves. States of arrest and compensation of morbid processes are often difficult to evaluate properly, so that prevalence figures tend to scatter over wide ranges of a statistical curve, and incidence figures are likely to be misleading measures of diagnostic prejudices and of the availability of facilities.

It is in the light of these considerations that the public health concept of prevention needs to be re-evaluated. Prevention is most clearly conceptualized

in the communicable diseases where the path of a known pathogenic agent can be accurately traced from its environmental sources to the human host. The concept is clear enough whenever it is possible to bar the path to the human body of a noxious agent, or to fortify the biological defenses of the body, as in the immunization procedures, or to protect the body by replacement against the absence of necessary nutrients and other substances, as in the deficiency diseases. Prevention by treatment, as in the case of the venereal diseases, is a somewhat less clear-cut concept, and the argument that it serves to break the chain of infection may not be pure rationalization but it at least introduces a new way of characterizing the idea of prevention.

However, these are all diseases of known etiology and discrete pathology in the classical tradition of medicine. It is interesting that we often talk about the prevention of the mental diseases as if their common elements were more important than their differentiated character as separate diseases. I am not even too sure that we would, as psychiatrists, reject this possibility out of hand. Still, from the point of view of public health's experience with prevention, such a state of affairs must seem primitive and possibly even deplorable.

When we use the term prevention in psychiatry we refer to several different kinds of activity. Perhaps the most venerable usage is in connection with the idea of early treatment. At the time of the beginnings of the child guidance movement it was thought that treatment of children might reduce the incidence of psychoses and juvenile delinquency. These hopes were not realized, but there still remains some prejudice in favor of treating children as young as possible, to prevent later troubles, and also with the somewhat naive thought that catching troubles early makes them easier to treat.

Another preventive notion in psychiatry is based upon a kind of theory of communication of unhealthy attitudes, according to which the mental health education of parents, and of teachers and others who influence the development of children, will tend to have a favorable effect on the mental health of oncoming generations. Whether any of this is valid is hard to say. We are dealing with a problem in which an infinity of variables frustrates efforts at measurement. We cannot say that these activities do any good, and we cannot say that they do no harm. Mental health education, in any case, familiarizes the population in general with the idea

of psychiatry as a medical discipline and probably creates a favorable climate of opinion for the public and private support of service and research expansion in the field.

To mention other preventive opportunities in psychiatry, a relatively recent development is the recognition of the importance of continuous mothering experience for the infant in the early years of life. This has been leading to the gradual replacement of infant institutions by foster home placement when the infant could not remain in his own home. Since affection deprivation in infancy leads to describable pathogenic results, any procedures that permit the infant to experience continuous mothering should have preventive value. Another observation is that of the burgeoning of delinquent behavior of youngsters in areas not provided with adequate recreational facilities and other opportunities for creative leisuretime activity. Here, too, the preventive measure seems self-evident, although it is curious to note how readily it is not applied, particularly in the construction of low-cost housing projects. Finally, one might mention the development by the Department of Welfare in New York City of recreational centers for the aged which seem to have been associated with some reduction in the rate of hospitalization of the population served.

It is perhaps worth noting that these are three diverse matters, covering very different kinds of problems and based upon both casual and systematic observation. On the surface there seems little to tie them together except that they are all related to social dislocation of one kind or another. However, in each problem area there are available, or could be developed, facilities and services which might contribute to an amelioration of the problem. This leads to the suggestion of a number of principles that might be applicable to the further development of the concept of prevention in psychiatry:

In the light of our present fund of knowledge about psychiatric illness the aim of prevention would seem to be the alleviation of distress rather than the cure of disease. Put in another way, it is to reduce the effects of illness by limiting or reducing disability and by restoring social compensation.

Prevention in a general sense may be defined as the sum total of all efforts directed toward individual welfare, either through physical, psychological, or social treatment of the individual, or by the establishment of opportunities for the individual

to satisfy basic needs for security, protection, and group belonging.

The preventive aspects of treatment at any age period are most effectively served when they are readily available at times of need whenever the individual is confronted with threats with which he is unable to cope unaided.

The study of the problems of specific developmental periods and of crucial life experiences is of central importance in a preventive program.

All professions dealing with people in crisis of any kind are in a position to make a contribution to community mental health through their professional practice, provided their training includes a dynamic understanding of human behavior.

Programs of community mental health should include the care and rehabilitation of the mentally ill as a shared responsibility of all agencies serving human need.

The coordination of programs of community mental health—using the term in a broad sense to include health and welfare as well as psychiatric agencies—is the single most pressing need in psychiatry today.

A review of these principles suggests that psychiatry might well work out a partnership of nonhierarchical participation with many kinds of community agencies in the struggle against mental illness. It also suggests that public health might play a role of great importance in the kind of program development which would implement these principles.

In this connection I quote a formulation offered by a public health teacher at a recent conference in Bethesda on Training for Community Mental Health, sponsored by the Public Health Service: "The tasks of community mental health in their broadest terms are essentially those of promotion, education, administration, and coordination. The techniques in their broadest terms are those of community organization, i.e., organization and utilization of all resources, which would include diagnosis, treatment, etc. The areas of knowledge brought to bear are those of psychiatry, psychology, social work, nursing, sociology, and anthropology, and the methods of statistics and research would be utilized."

Community organization may be characterized as a method of enlisting all relevant resources in the community for the support of and for the promotion of the aims and objectives of health and welfare

programs. The tradition of community organization is by and large one of vertical compartmentalization, the different programs establishing their own spheres of interest and influence, often on a competitive basis with other programs. For example, social agencies have a community organization of their own, which is usually quite distinct from that of the various health agencies, and these in turn show some tendency to organize in competition with one another, tuberculosis vs. cancer vs. heart, etc. To some extent, this vertical diversity is a reasonable method of appealing to the community groups with a special interest in the particular program, and it also serves the purpose of maintaining the emotional attachment of its adherents. Health and welfare councils in most of the larger communities generally serve a mediating rather than a coordinating role.

The organization of the community for mental health has been following the pattern established for the other health and welfare programs, even where the more pervasive importance of psychiatry is recognized, as in the recent Community Mental Health Services Act of New York State. The great advance of the New York State legislation, which is outstanding in its pioneering importance, is its acceptance of the need for coordination as well as expansion of psychiatric services at the local level, but it should be noted that this is a specifically psychiatric and not a mental health program. This is not to suggest that the coordination of community psychiatric services, including clinical, after-care, consultant, and educational activities, is not of vital importance. However, the program does not have a mental health objective in the sense in which I would use the term. While this kind of differentiation may seem like the proverbial straining at a gnat, it is of crucial importance to the consideration of a public health point of view toward the mental and emotional problems of a community.

Perhaps my concept may be clarified by a brief discussion of the use of psychiatric consultation to nonpsychiatric agencies. The rationale of the practice of such consultation is clear enough. The social and health agencies serve people with the entire gamut of psychiatric problems, from simple situational reactions to overt psychoses. Because psychiatric consultation is necessarily limited, it tends to be reserved for the client problems that are most puzzling or disturbing to workers, in other words

for the more severe cases. The consultant thus tends to become involved in cases which challenge his clinical acumen and skill. Even where the case remains in the agency and is not referred to a psychiatric facility, work with the client will tend to develop along lines determined by the frame of reference of the psychiatrist, with due recognition to psychopathology and dynamics. Even where a gifted consultant has familiarized himself with the function of the agency he serves, and has adapted himself to its administrative setting, his activity is still likely to be oriented toward the severe psychiatric problem.

One might say that the use of psychiatric consultation represents an important extension of the psychiatrist's opportunity to help a great many deeply disturbed individuals who might otherwise never come to his attention, who might reject direct psychiatric assistance, but who might be able to achieve alleviation of distress through a relationship to a worker around a social or health problem. Only one special aspect of consultation has been suggested but perhaps it will carry the point that it is an activity often or even largely devoted to the pursuit of psychiatric goals with seriously disturbed persons.

Such an activity might be contrasted with one of the principles suggested above, i.e., that the preventive aspects of treatment are most effectively served when they are readily available at times of need whenever the individual is confronted with threats with which he is unable to cope unaided. The threats might include not only psychiatric problems as such, but also physical illness, marital stress, parent-child disturbances, parental anxieties, and anxieties of aging, of social isolation, or of economic deprivation. These are the kinds of problem for which many different services are generally available, for example, psychotherapy, counseling, casework, medical treatment, group treatment, or welfare assistance. From the point of view of a mental health program then, psychiatric services are merely one of the many in a community which are responsive to the emotional problems of people in a large variety of biological, psychological, or social situations of stress.

In any community, then, the agencies serve people with every diagnosis in the psychiatric nomenclature, but the choice of agency by the client is the result of his own particular way of regarding his problem, and this in turn is dependent on factors of social class position, social role, previous experi-

ence in receiving help, and the community mythology relating to the functions of the various agencies. For example, we have found at the Psychiatric Clinic of New Haven Hospital that we are unable to engage in psychotherapy patients in the lowest socioeconomic class and are interested in investigating how such patients receive help with their problems, if they do at all. In other words, the patient is not a respecter of agency function; he respects only his own prejudices and predilections concerning the help he thinks he needs. To meet this problem one would have to develop a horizontal concept of community organization, starting with the idea that all agencies serving vital human problems carry a mental health responsibility. In order to implement this responsibility it would be necessary in the first place to include in the training of all agency workers a core content in the behavioral disciplines oriented to specific professional need, and, second, to develop a theoretical and practical framework for the planned coordination of agencies in their mental health functions. Graduate training in public health of psychiatrists, psychologists, social workers, and nurses, with a special emphasis in mental health, might supply the field of community mental health with the coordinating personnel it requires.

These remarks may be brought to a close with some consideration of the problem of horizontal community organization for mental health. The mutual interdependence of services is most obvious when any one is lacking in a community program. For example, most communities clamor for a psychiatric clinic when they do not have one, but for a newly established clinic to work out its proper place in the family of agencies often takes years of laborious interpretation through mazes of misunderstanding. Likewise, it is not always clearly understood that a psychiatric clinic cannot be expected to realize its value in a community that does not provide adequate basic health and welfare services.

A psychiatric clinic and a family service agency, for example, play complementary roles in a community program, each supporting the uniqueness of function of the other. In the absence of the one, the other finds itself pressed to deal with problems for which its workers are equipped neither by training nor experience. However, the problem of relationships between a psychiatric clinic and a family service agency receives at best the most haphazard and unsystematic consideration, so that often the values inherent in each agency, particularly in their

complementary roles, are not made fully available to the community. This statement can be generalized to include other community agencies and their interrelationships, agencies such as a department of welfare, a juvenile court, a recreational center, a medical or surgical clinic in a general hospital, etc.

A mental health worker will concern himself with the identification and study of problems of this kind. He will study the function of each agency in relation to the emotional problems of its clients and will seek to find some way of conceptualizing the coordinative realities and potentials in the family of agencies in a community. He will enlist the interest of agencies and of agency councils in this over-

all approach and will develop a process of statistical study of relevant problems and the administrative machinery to maintain agency interrelationships with respect to the mental health aspects of services, particularly in connection with multifaceted community problems like juvenile delinquency and medical and psychiatric rehabilitation. Such a public health approach, utilizing existing resources to their fullest capacity, uncovering gaps in services and developing new programs to meet new needs, on the level of coordinated community study and planning, holds out the promise of a significant advance in the treatment, prevention and control of mental illness.

INFANT RESUSCITATION

VIRGINIA APGAR, M.D., *New York, N. Y.*

The Author. Professor of Anesthesiology, Columbia University College of Physicians and Surgeons, New York, New York

APPROXIMATELY six per cent of the infants born at Sloane Hospital for Women in New York have severe respiratory depression at birth. To treat these babies successfully, everyone in the delivery room should be familiar with sound principles of resuscitation. "Everyone" includes the obstetrician, the anesthesiologist, the pediatrician, the medical students and the obstetric nurses, both graduate and undergraduate. The task of resuscitation should not be assigned to one of these persons or groups. The infant does not "belong" to the obstetrician, the pediatrician or the anesthesiologist. The most experienced available person should manage the severe depression promptly; nowhere is the success of teamwork more evident than in the delivery room.

1. FREE AIRWAY

At the moment of birth, consideration is given to maintaining a free airway. The infant's head always should be lower than the trunk during delivery and until the pharynx has been examined and aspirated.¹ Gravity is a more important aid than any mechanical device. After prompt division of the cord between clamps, the infant, still in the head-down position, is placed in a bassinet with the head lowered. If the first inspiration consists of pharyngeal material rather than air, a strong basis is laid for development of secondary atelectasis, pneumonia and death in the first 48 hours. Mouth suction or electric suction (with a rubber catheter and trap) is used to empty the pharynx as long as any material remains in it. Prolonged suctioning is harmful both because of the extreme bradycardia produced and because of removal of oxygen from the pharynx. After the pharynx is empty, almost all infants can be made to cough or sneeze (inspire deeply as well)

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by placing the end of the catheter just inside the nostril. After such a cough or sneeze the pharynx should be suctioned briefly again.

Amniotic fluid and its contents normally fill the tracheobronchial tree before birth, and although the fluid is easily absorbed by the pulmonary circulation, and the foreign debris moved upward by ciliary action, the volume which the infant must handle is less if he can expel some by coughing.

Usually infants do not require further attention. One group² believes that leaving the stomach empty has a favorable effect in preventing the later development of pulmonary complications, but we have not found such a relation as yet.

If artificial ventilation is necessary because of persistent apnea, it is essential to keep the tongue from acting as an obstruction in the pharynx. The tongue of a limp child lying on his back falls backward against the bodies of the cervical spine and obstructs the passage of air from either the nose or mouth. A small plastic pharyngeal airway placed between the tongue and palate corrects this obstruction immediately and always should be inserted if some type of positive pressure breathing is planned. If the infant has enough tone to keep his tongue forward in his mouth, he does not need the artificial ventilation.

When inflation of the lungs does not produce a slight rise of the upper chest, some obstruction still is present. One should rule out choanal atresia by slipping the catheter into the nasopharynx; this rare anomaly necessitates tracheostomy. More often the obstruction is at the larynx, and direct laryngoscopy is immediately indicated if efforts at ventilation do not improve the child's condition after two to three breaths. We have encountered both blood clots and vernix caseosa as the cause of obstruction, and these were removed easily by direct suctioning. If a complete laryngeal web is seen, immediate tracheostomy is indicated.

2. VENTILATION

The best ventilation is accomplished by the infant himself, and very few babies need any mechanical assistance. After making sure the pharynx is empty, a brisk slap on the soles of the feet will bring about sharp inspiration and precipitate crying. Obviously a child deeply depressed and in shock is not so stimulated. If respirations are very inadequate or absent, some type of IPPB (intermittent positive pressure breathing) should be applied. Numerous

mechanical devices are available for this purpose, or mouth-to-mouth inflation is always available and does not get out of order. The principle of application is a short, sharp "puff." Better results and less lung damage are produced by one or two such puffs than by a low pressure application of several seconds' duration.

The best gas to use is oxygen-enriched air. We know that excessive exposure to 100 per cent oxygen produces secondary atelectasis, pulmonary hemorrhage and retrolental fibroplasia in premature infants. It is doubtful whether a few seconds' use of 100 per cent oxygen in the delivery room will be followed by such complications, but this procedure will be discontinued when a practical method of applying positive pressure with a mixture of air and oxygen has been developed.

If application of positive pressure using a face mask does not bring improvement in two to three breaths, direct laryngoscopy and insertion of a flanged endotracheal tube are indicated. The flange prevents the tube from being inserted below the carina and allows a snug fit at the cords. The endotracheal route is the most efficient and direct in ventilating lungs, and the entire delivery room personnel should take all opportunities to practice intubation in warm, dead infants.

3. POSITION

The head-down position from the moment of birth already has been stressed. There is much current discussion of the proper position of the infant in relation to the placenta before the cord is clamped. Since no competent valves function in the umbilical cord, blood volume easily can be shifted to the infant or to the placenta. In the case of a sensitized Rh infant it is recommended that the baby be held above the level of the placenta for five to ten seconds before clamping the cord, thus lessening the likelihood of hypervolemia after exchange transfusion. We feel strongly that premature infants should not be held below the level of the placenta, for a large increase in blood volume will result. We believe at present that this hypervolemia is related to the high incidence of hyaline membrane in premature infants. The best "routine" position is level with the placenta. The cord should be clamped promptly to allow immediate attention to the airway. After respiration is established, a head-up position will provide a larger thoracic cage for the expanding lungs, since the weight of the viscera

TABLE 1
EVALUATION OF THE NEWBORN INFANT; METHOD OF SCORING

SIGN	0	1	2
Heart rate.....	Absent	Slow	Over 100
Respiratory effort.....	Absent	Slow	Good
		Irregular	Crying
Muscle tone.....	Limp	Some flexion of extremities	Active motion
Response to catheter in nostril.....			
(tested after oropharynx is clear).....	No response	Grimace	Cough or sneeze
Color.....	Blue	Body pink	Completely pink
	Pale	Extremities blue	

lowers the diaphragm. At present we feel this position is desirable.

4. TEMPERATURE

The time-honored habit of keeping babies warm at all times is undergoing investigation. Cooler temperatures reduce tissue metabolism considerably, and warm ones raise it. Theoretically, cooling would be of aid to small, sick infants with respiratory insufficiency. There are few data regarding the normal behavior of the temperature after birth. The full-term infant's temperature drops 2 to 3° F., whereas the premature infants may drop 4 to 8° F. and remain at that level for one or two weeks, apparently without detriment. A controlled experiment is under way at the Babies Hospital to study the survival of premature infants at different environmental temperatures.

5. HUMIDITY

Controlled experiments do not provide evidence that excessive humidity or vaporization of various wetting agents improves survival in the newborn period.

6. USE OF DRUGS

Rarely are agents other than oxygen indicated in the delivery room. If maternal depression exists, and if it is likely that it was caused by an opiate, intravenous injection of 0.25 mg. of *N*-allylnor-morphine into the umbilical vein is worth a trial. If this is done and the diagnosis is in error, moderate sedation is produced in the infant.

Antibiotics always should be used after difficult resuscitation, and digitalis frequently is of help in severe cardiac problems.

7. SCORING

Every infant is evaluated 60 seconds after birth according to a simple, objective scale, reproduced in table 1.

8. GASTRIC ASPIRATION

After respiration is well established, every infant's stomach is aspirated by introducing a soft rubber catheter and aspirating the contents. The main purpose is to rule out esophageal atresia, the second purpose being to measure the gastric contents. If the tip of the catheter is not seen in the left half of the abdomen, a stethoscope is placed over the abdomen and a short puff of air is blown into the catheter. No noise indicates atresia.

9. IMMEDIATE NEONATAL DIAGNOSIS OF OPERABLE ANOMALIES

I already have mentioned esophageal atresia. If more than 50 cc. is aspirated from the infant's stomach, the abdomen should be x-rayed within the hour to rule out duodenal or jejunal atresia. Absence of gas below the pylorus indicates atresia and immediate operation.

The chest should be auscultated in the first few minutes. A shift in loudest cardiac sounds and absent breath sounds in one side of the chest suggest diaphragmatic hernia, another operable emergency.

Imperforate anus should be treated by operation immediately. The newborn infant is most resistant to surgical assault and anesthesia in the first 24 hours after birth. Every delay in diagnosis of an operable anomaly jeopardizes his chances for survival.

10. MATERNAL POLYHYDRAMNION

A history of maternal polyhydramnion should lead to an especially thorough search for anomalies, most of which are operable. We have found the following anomalies to be directly associated with polyhydramnion: anencephalia, hydrocephalus, trachéo-esophageal fistula with esophageal atresia, diaphragmatic hernia, congenital cardiac disease, duodenal and upper jejunal atresia, volvulus, and

perforated stomach. Rapid diagnosis in the delivery room is one of the most helpful means of reducing neonatal mortality.

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MIDDLE LOBE SYNDROME IN A THREE YEAR OLD CHILD TREATED WITH LOBECTOMY

ALFRED T. ST. JAMES, M.D. and ROLF KATZENSTEIN, M.D., *Meriden*

THE Middle Lobe Syndrome is a term coined by Graham, Burford and Mayer¹ in 1948 to describe chronic atelectasis and pneumonia of the middle lobe; localized bronchiectasis usually resulting in long standing cases. The parenchymal and bronchiolar changes are due to bronchostenosis, due in turn to enlargement of the peribronchial lymph nodes about the middle lobe bronchus. At times the bronchus may be ulcerated into by one or more of these nodes, but more often the bronchial narrowing is due to compression from without. The lymphadenopathy may be tuberculous or nonspecific. Ulceration of the bronchus is not seen in the nonspecific type of inflammation.

There is an anatomic reason why the middle lobe is involved so much more frequently than the other pulmonary divisions. Brock² has pointed out that the middle lobe bronchus is especially long and narrow. The lymph nodes are so arranged about its origin that even moderate enlargement will produce bronchial compression and stenosis. These same nodes also receive drainage from the upper and lower lobes and hence are more liable to infection.

Approximately half of the reported cases are due to tuberculosis, and the remainder to nonspecific inflammation. It is chiefly a disease, or rather an affliction, of people in the third decade and older. The syndrome is unusual in children, especially the

Dr. St. James. *Senior Associate Attending Surgeon, Meriden Hospital*
Dr. Katzenstein. *Pathologist, Meriden Hospital*

SUMMARY

The case of a three year old child with middle lobe syndrome manifested clinically by hemoptysis is presented. The typical lymphadenopathy about the middle lobe bronchus was found at operation. The child was treated by middle lobectomy and discharged in good condition after an uneventful postoperative course. The patient has been followed now for six months since her resection and to date she has been completely asymptomatic. There has been no recurrence of hemoptysis or pulmonary infection.

nonspecific variety. Chronic collapse of the middle lobe due to tuberculosis has been described in children, as, for instance, the cases reported by Harper,³ Court,⁴ and Bryant,⁵ each of whom has reported one. The signs and symptoms are due to the chronic changes produced in the lung and hence are varied: chronic cough, abundant expectoration, frequent colds, recurrent pneumonia, and hemoptysis. The last mentioned sign was present in about one third of reported cases. It was the presenting complaint in the case reported herein.

CASE REPORT

S. M., a three year old white female child, was first seen on September 3, 1956 because of hemoptysis. The mother stated that in the early spring of that year the child had a respiratory infection with fever. In May the child had her first bout of hemoptysis, followed in approximately a month by a recurrence of same. In August of the same year there was a third hemoptysis, and one of the authors (A. S.) was called to see the patient on September 3 because of a fourth hemoptysis. These hemoptyses did not consist of only blood-streaked sputum, but rather were gross. It is estimated from observation in the patient's home that the fourth hemoptysis consisted of approximately 15 to 20 cc. of bright red blood.

Physical examination at that time revealed a well developed, overweight, three year old child, appearing neither acutely nor chronically ill. The temperature was 100° orally. There was no inflammation of the nose, throat or ears. The cervical lymph nodes were not enlarged. The lungs were clear to percussion and auscultation, and the remainder of the physical examination was within normal limits.

The patient was admitted to the Meriden Hospital and an x-ray of the chest obtained. This revealed the presence of an infiltrate in the right middle lobe. It was felt that the child probably had a pneumonia and she was given a ten-day course of broad spectrum antibiotic therapy. At the conclusion of this interval another x-ray of the chest was obtained, and the findings were essentially the same as on previous examination. Physical examination remained unchanged. the patient was afebrile.

She was next given a skin test with purified protein derivative in two strengths, both of which were negative, thus probably excluding tuberculosis. On October 5, 1956 bronchoscopy was performed. With the exception of some reddening of the orifice of the middle lobe bronchus and increased secretions, the examination was negative. The orifice of the middle lobe bronchus was carefully inspected and no foreign body or obstruction found. The segmental bronchi of the middle lobe were not visualized. Bronchogram was performed at the conclusion of the bronchoscopic examination. There was good filling of the entire right lung with the exception of the middle segment of the right middle lobe. All of the bronchi visualized appeared normal. The infiltrate of the middle lobe now had more of a characteristic appearance of atelectasis. It was, however, essentially unchanged since the first examination.

Chiefly because of the child's age, it was elected to adopt a period of watchful waiting. About the 15th of November the patient again had an hemoptysis, and this then became a daily occurrence. It was decided that this could not be permitted to continue, and so on November 26 the child was again admitted to the Meriden Hospital and on November 28, 1956 was operated upon. At operation the medial segment of the right middle lobe was found to be airless and indurated. There was a peripheral vascular adhesion between the middle lobe and the pericardium; there were no other adhesions, and there was no fluid in the pleural cavity. The origin of the middle lobe bronchus was completely surrounded by multiple large and adherent lymph nodes measuring up to 1 cm. in diameter. These nodes also extended

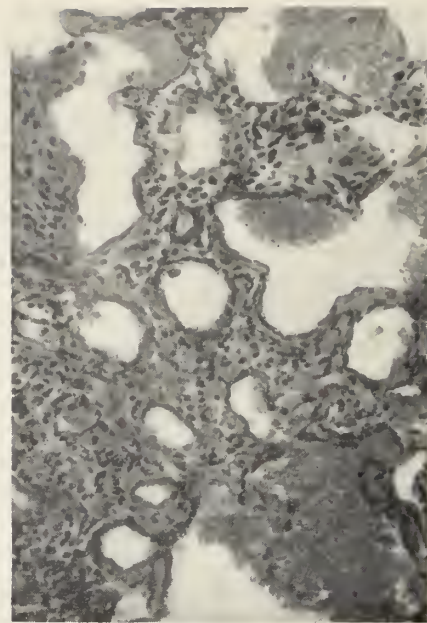


FIGURE 1

Interstitial pneumonia and metaplastic proliferation of bronchiolar epithelium

along the upper and lower lobe bronchi but did not encircle these as they did the middle lobe bronchus. A middle lobectomy was performed without incident, and the chest closed with underwater drainage. A film of the chest taken 48 hours postoperatively revealed the lung to be fully expanded and an absence of exudate in the pleural space. The drainage tube was removed at this time. The patient had a benign, uneventful postoperative course. The sutures were removed on the sixth postoperative day. A repeat x-ray examination of the chest revealed the lung to be expanded and clear. The costo-phrenic sinus was also clear. The child was discharged in good condition on December 7.

PATHOLOGICAL FINDINGS

The middle lobe of this lung measured 13 × 11 × 6 cm. Its outside was smooth. Its color was dark blue and its consistency in the center was diffusely more dense than the marginal zones where air contents can be felt. Near the plane of ablation of the main bronchus a good sized lymph node approximately 8 mm. in diameter was seen. It was possible to follow the bronchial tree with a fine pair of scissors; however, there was obvious thickening of the bronchia wall in the major bronchi with distinct dilatation of medium sized and small bronchi. The pulmonary parenchyma grossly presented extensive consolidation by what appeared to be extravasated blood.

The section of the bronchus near the plane of ablation showed papillary elevation of the mucosa into the lumen. There was diffuse hyalinization and thickening of the basement membrane as well as a varying degree of predominantly mononuclear cellular infiltration that had extended down to the cartilage. The epithelium of the bronchus was actively mucus producing and in some places showed some

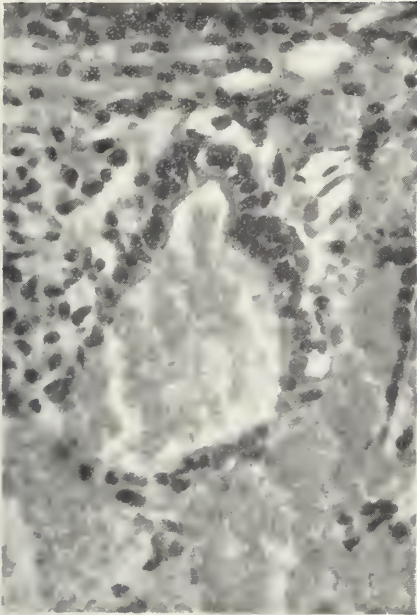


FIGURE 2
Metaplastic alveolar lining

that, an unorganized lymphocytic infiltration followed these structures. The small bronchi and bronchioli showed a remarkable dilatation with what appeared to be elongation and distinct flattening, and in some places true metaplasia of their lining epithelium (Figure 1). Occasionally this lining epithelium had grown out into alveolar spaces where it had formed gland-like structures. The alveoli appeared of regular size. They contained fibrinoid matter associated with some infiltration of white blood cells, and there was also fibrinoid change of some of the alveolar walls (Figure 2). Occasionally a small focus of mononuclear elements was seen in these structures. Superimposed upon these chronic changes, there was extravasation of red blood cells into the interstitium as well as the alveoli.

A diagnosis was made of chronic bronchitis, bronchiolitis, ectasis of small bronchi and bronchioli, and focal interstitial pneumonia.

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metaplasia. This was quite prominent in some of the ducts of the mucous glands of the bronchial wall. True lymphoid tissue with germinal centers was seen in close association with small and noncartilage bearing bronchi. In addition to

THE PHYSICIAN AND FLUORIDATION

DAVID BABBOTT, M.D., *Wellesley Hills, Massachusetts*

IN recent years many articles dealing with fluoridation have appeared in both lay and scientific publications, but surprisingly few have been written either by or for practicing physicians. Most of us are vaguely aware that fluoridation is a "good idea;" some of us have gone on record as favoring the program, and yet the vast majority of Connecticut is without its benefits. Perhaps one of the reasons this condition exists is that we as physicians are not sufficiently aware of the safety, efficacy, technical ease of administration and financial feasibility of fluoridation. It is hoped that this review will bring these factors to the fore, so that we may be more effective spokesmen in this field.

The concentration of fluoride is usually spoken of in terms of parts per million (ppm). It is well known that the natural water supply contains varying amounts of this ion in different locations. Food-stuffs also vary in their fluoride content, and there are statistical tables available to ascertain these figures. The Hartford drinking water, for instance, contains 0.0 ppm of fluoride; Aurora, Illinois has 1.0 ppm; Gillette, Wyoming has 4.0; Bartlett, Texas has 8.0 ppm and Climax, Colorado has 35 ppm of fluoride occurring naturally in its drinking water.^{7,14,15} Beer contains 0.20 ppm, steak has 1.28 ppm, sardines in olive oil, 16.1 and Lipton's Tea has 18.3 ppm to name a few.¹⁰ And, as a matter of fact, it has been said that the only way to avoid ingestion of fluoride is to adhere to a diet of cabbages, cauliflower and beets boiled in distilled water.² Milk is low in fluoride. It contains approximately 0.09 ppm. Interestingly enough, cows given added fluoride in their drinking water or grain show but minimal elevations in fluoride concentration of their milk. The same holds true for lactating humans as well. Studies have shown that the human placenta has the ability to concentrate the ion to a level approximately three times as high as that found in circulating maternal blood. This is true whether the daily intake of fluoride is at or below optimum amounts.⁴

The Author. *Former Resident in Medicine, Hartford Hospital, Hartford, Connecticut*

SUMMARY

Fluoridation is one of the most hotly debated public health issues of the day, and yet physicians have in general not been active in this field. Perhaps one reason for this inactivity is that physicians are not sufficiently aware of the problems involved in fluoridation.

In this review an attempt has been made to cover the main points in the arguments against fluoridation, and is followed by a discussion of the safety, effectiveness, economic feasibility and ease of administration of the program. The hope is expressed that once aware of the value of fluoridation physicians may be more effective spokesmen in this field.

Inhabitants of Hartford where there is little dietary ingestion of fluoride would be expected to have blood levels of about 1 microgram of the ion per 100 cc. of blood.⁶ When the dietary intake is increased, there is but a transient increase in circulating fluorides. The ion does not stay in the blood stream. Where does it go? There are three main metabolic pathways for fluoride: renal excretion, deposition in bone, and under certain conditions, excretion through the skin.

It should be stressed that the important factor in terms of dental caries protection (as well as toxicity) is the amount of the ion ingested, not its concentration, and it has been determined that the optimum intake is 1 to 1.5 mg. of the ion per day. Statistics have shown that the average daily water intake amounts to between one and two liters. The optimum dilution then is approximately one part per million, for at this concentration one liter contains 1 mg. of fluoride ion. This concentration may be thought of as three drops in a bath tub full of water.

When up to a few milligrams of fluoride are ingested, much of it is promptly excreted in the urine. One fourth of a given dose will appear in the urine within three hours.⁶ Like chloride and bromide the fluoride is filtered through the glomerulus. Unlike its halogenic cousins, however, which are 99 per cent resorbed by the kidney tubule, the fluoride ion is more selectively excreted by the kidney so that its concentration in the urine is greater than that in body fluids. Of interest and importance is the fact that in experimental animals with induced renal damage, and clinically in humans with severe renal disease, there is no significant decrease in the kidney's ability to excrete fluorides.^{1,6}

As far as bone metabolism is concerned, there is competition between the fluoride ion and OH^- groups for specific positions in the crystal lattice of bone. The extent of the fluoride deposition is dependent on physical-chemical laws, and as far as the bone is concerned this is a perfectly satisfactory arrangement, for in recommended amounts there is no structural damage caused by this exchange. Following cessation of ingestion of fluoride there is slow mobilization of the ion from the bone, with subsequent excretion by the kidney.⁶

Acute fatal fluoride poisoning can successfully be accomplished by ingestion of between five and 10 grams of the ion, and as the antifuoridationists point out, both rats and humans can be annihilated by an overdose of fluoride. Symptoms include those of GI tract irritation, namely abdominal cramps, nausea, vomiting and diarrhea.⁶ In addition there are central nervous system, respiratory and cardiovascular system effects from acute poisoning.⁵ Some of these manifestations have been laid to precipitation of body calcium by the fluoride, but there are enzymatic disturbances caused by the fluoride that are doubtless of more importance. Because of the body's remarkable ability to excrete fluoride in the urine, plus its rapid disappearance from the circulation into bone, if a patient does not die within four hours after ingestion, his chances for ultimate survival are good.

In children the first manifestation of fluoride toxicity is the appearance of focal areas of discoloration or mottling of the teeth. In a small percentage of children this may occur with as little as two milligrams of the ion per day, but in these doses mottling is rarely detectable to the naked eye. As the daily ingested amount of the ion is increased to five milligrams the mottling becomes more

severe. In its mild form there is no structural damage done to the teeth by mottling, which can only occur if the ingestion has taken place during the first twelve to sixteen years of life when the enamel-forming organs are functioning. Once a tooth has erupted, it can no longer become mottled. On the other hand, the beneficial effects of fluoride ingested during childhood last into adult life. The factor of safety between the recommended daily intake and the appearance of significant mottling is at least five times.

There is no question that prolonged intake of large amounts of fluoride ion produce serious skeletal abnormalities manifest chiefly by increased calcification of bones and of the broad ligaments of the back, producing serious immobility. This condition, known as crippling fluorosis, requires a daily intake of between 20 and 80 mg. of fluoride for periods of ten to twenty years in order to be produced. Obviously if these conditions are met during childhood there will be severe mottling of the teeth in addition to the skeletal abnormalities. The factor of safety between recommended intake and this condition is 20 to 80 times. Clinically the condition has been found among certain industrial workers where high concentrations of fluoride dust have been known to exist in the atmosphere.

Less severe than crippling fluorosis is a condition known as osteosclerosis in which there is x-ray evidence of increased calcific deposits in bone. This may or may not be associated with skeletal symptoms, and may occur after prolonged ingestion of 8 to 20 mg. of the ion per day. The factor of safety then is of the order of eight to twenty times.

Unlike many fields of medical advance that have had to be preceded by animal experimentation and human trials with essentially unknown results, the problem of fluoridation is unique in that there are many areas of the world available for study where the natural fluoride concentration in the drinking water is already known. Population studies in these areas such as Bartlett, Texas with 8 ppm and Aurora, Illinois with 1 ppm gave ample information as to both the prophylactic and toxic effects of varying amounts of fluoride ingestion. With this information clearly known, studies could then be undertaken in communities where applied fluoridation was introduced, and comparisons made with control populations. These pilot studies, started in the mid-1940's, have conclusively shown that there is no difference in effectiveness of caries prevention in areas where

the drinking water contains naturally or purposely occurring fluorides in optimum concentrations.

Technically the task of adding measured amounts of fluoride ion into measured amounts of water is simple. In actual practice almost all of the water works incorporating fluoride into the water supply use sodium fluoride or sodium silicofluoride. As this works out, approximately 18 pounds of the sodium fluoride or 14 pounds of the sodium silicofluoride is added to each million gallons of water.¹⁵ This produces a concentration of 1 ppm, and in this minute dilution the fluoride is both tasteless and odorless. The principles involved in this operation are both safe and simple. To fluoridate the water supply of Greater Hartford, for instance, would require but three installations that would service upwards of half a million persons. It is technically impossible to cause acute fluoride poisoning by adding too much fluoride to a water supply because the factor of safety is of the order of 2500 to 5000 times.

If these concepts are true why should there be so much opposition to fluoridation? Part of the answer doubtless lies in the fact that there are in our midst uninformed, malcontent and vociferous and psychopathic citizens who have blocked it. The same type of opposition existed some fifty years ago when chlorine was first being introduced into the water supply. The complaints then and those pertaining to fluoridation now show striking similarity. The following quotation will illustrate this likeness. "Since drinking water has been chlorinated, there has been a notable increase in endemic goitre, cancer, rheumatoid arthritis, neuritis and other diseases that the predisposition, if not the actual cause, of some of these diseases is due to changes produced in the drinking water by chlorination."¹¹

It is claimed that the program of fluoridation is economically unfeasible because statistics have shown that less than one per cent of a water supply is used for human consumption, and that only a small proportion of this one per cent would be used by the children who would benefit most from the program. This doubtless is true, but what may not be generally known is that the per citizen cost of fluoridating a water supply for a year amounts to approximately ten cents. Contrast this with the dental bill in this country that exceeds one and one half billion dollars each year,² and the known fact that fluoridation, when used correctly reduces dental caries by greater than 60 per cent.⁷ There is no more economical or effective way of accomplishing

this goal than by fluoridating water supplies. From a public health point of view topical application of fluoride, fluoride mouthwashes or fluoride-containing compounds added individually to the daily diet cannot approach the effectiveness of fluoridating a water supply.

The antifluoridationists argue that to contaminate God's pure water with poisonous fluorine is a violation of man's freedom of religion. It should be pointed out that for the most part the water we drink is pure because God's own impurities have been removed.

It is maintained that it is unconstitutional to alter the fluoride content of our drinking water; that this is in some way an aqueous violation of civil rights. This question has been taken to the courts in over one fourth of our states; it has come before the supreme court in California, Louisiana, North Dakota, Ohio, Oklahoma, Washington and Wisconsin. It has come before the Supreme Court of the United States. In every instance the highest courts have held that this procedure is a valid and reasonable exercise of the police power of the state in the interest of public health, and that fluoridation does not violate any of the rights of individuals vested in them by federal and state constitutions.¹³ Fluoridation is legal.

Finally the opponents claim that fluoride added to the drinking water increases the incidence of hardening of the arteries, heart trouble, cancer, tuberculosis, diabetes, poliomyelitis, stillbirths and nervous disorders. Fluoridation of drinking water is further reported to increase the incidence of nymphomania, financial anxieties, and acts to weaken the will of the people to resist Communism. The simple truth of the matter is this: fluoridation has been exhaustively studied. There is no evidence whatsoever to indicate that in recommended concentrations fluoride added to the drinking water is associated with any increased incidence of degenerative, neoplastic, infectious or other diseases. Fluoridation is safe.^{1,2,3,6,7,8,9,15}

The following major cities have instituted fluoridation: Chicago, Philadelphia, Baltimore, Cleveland, Washington, D. C., San Francisco, Pittsburgh, Milwaukee, Buffalo and Minneapolis. Over 32 million of our country's population is drinking water fluoridated by man. Four to five million more live in areas where the concentration is close to or at optimum levels. Another seven and one half million people live in areas where there is greater than

optimal concentration of fluoride. It is of interest that in these areas the U. S. Public Health Service has advocated procedures to lower the concentration to recommended levels.

Here in Connecticut there are only three areas where there is naturally occurring fluoride in effective amounts. These private water supplies service only a handful of families. Fourteen other areas have less than optimal concentrations of the ion. There are five localities that are using applied fluoridation. The first of these was the Southbury Training School which began fluoridation on a trial basis in 1945 when the pioneer study of Newburgh and Kingston, New York was getting under way. The control population for the Connecticut study was the Mansfield Training School. By 1951, four years before the study was to have ended, the Connecticut State Department of Health recognized the benefits and safety of the program, ended the pilot study and began fluoridating the drinking water of the Mansfield Training School.

One final plea: We know the program of fluoridation when carried out in accordance with accepted public health practices is over 60 per cent effective in preventing dental caries. We know it is safe, practicable and financially feasible. The best medical, dental and public health minds in this country have supported the program. We do not have it here in Connecticut, not because those best qualified to judge the merits of the program are against it, but because of the small but vocal groups that oppose the measure. Their voices should not be strong enough to prevent realization of one of the most significant advances in public health of our times. The challenge is ours.

ADDENDUM

Since this paper was submitted for publication fluoridation has been accepted in Hartford. This advance is a real achievement for those who have worked so hard to put the program over in the State of Connecticut.

ACKNOWLEDGEMENT

The author wishes to express his appreciation to Dr. Leonard D. Menczer, D.D.S., director of the Bureau of Dentistry of the Hartford Health Department, and president of the Connecticut Public Health Association. Dr. Menczer not only kindled the author's interest in this field, but was most generous with his literature on the subject and his time in consultation and reviewing of the manuscript.

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THE CONTROL OF FATIGUE IN THE AGED

THEODORE G. KLUMPP, M.D., *New York, N. Y.*

FATIGUE is the most prevalent limiting factor in the pursuit of an active, happy and useful way of life by older persons.

Fatigue is both a symptom in itself and a symptom complex. Generalized fatigue is a vague physical, mental and emotional depression known to everyone but difficult to describe specifically except through synonyms such as weariness, weakness, tiredness, exhaustion, lassitude, malaise, spent, strained, overworked and "worn out." It is often accompanied by loss of mental acuity, impairment of memory and perception, headache, disturbances of emotional and reflex reactivity, loss of visual acuity and accommodation, functional gastrointestinal and sphincter disorders, changes in cardiac rate, rhythm and circulatory tone, and muscular weakness and tremor. Fatigue is also accompanied by many bodily chemical and endocrine changes, reference to which is beyond the scope of this paper.

Fatigue is an almost universal symptom of disease. It is often the chief complaint and sometimes the only one. In view of this the symptom should always be taken seriously and steps taken to find the underlying cause.

A painstaking analysis of the patient's physical, mental and emotional status to disclose the possibility of disease, unhygienic patterns of living, or emotional conflicts that may be the basis of, or contribute to, undue fatigue should be instituted. Anemia, tuberculosis, diabetes, nephritis, cardiac decompensation, and thyroid dysfunction, are a few of the many specific causes of undue fatigue. It is important to keep in mind that the "small cerebral hemorrhages" of Alvarez may be followed by easy fatigability and thus bring the patient to the physician's attention. The use of tobacco and alcohol—and this need not necessarily be excessive according to ordinary criteria—should be considered as possible cause of fatigue. But the physician

The Author. *President, Winthrop Laboratories,
New York, New York*

SUMMARY

Fatigue, the most prevalent limiting factor in the lives of older persons can often be controlled. Atrophy of disuse, affecting mental and emotional capacities as well as physical, and loss of incentive motivation and interest are among the causes that can be corrected. Traditional philosophies concerning the nature of fatigue in age and its correction must be questioned in the light of present day physiological thinking.

should guard against arbitrarily banning these and other pleasures. They may represent the solaces of a lifetime and indeed are more likely to have value in overcoming fatigue than otherwise. In this as in other things, a brief trial period of abstinence or curtailment may tell the story.

The importance of obesity as an etiological factor in fatigue cannot be overemphasized. Loss of weight is usually of decisive benefit although this may not always become apparent until the weight is stabilized at a lower level.

Emotional factors often play an important role in fatigability. They should not be overlooked.

In considering the significance of fatigue it must be kept in mind that fatigue is also a normal incident of normal living. Some individuals are unduly sensitive to their own feeling tone and are unwilling to tolerate the minor deviations from the feeling of well-being that occur to everyone. Such patients need only reassurance. However, when the pattern of fatigue has recognizably changed, or the symptom is out of proportion to the age or mode of life, or it imposes an undue limitation on ordinary activities, it should not be dismissed lightly.

Presented at the Hartford Hospital, Hartford, Connecticut, March 30, 1957 as a Newington VA sponsored lecture

Connecticut State Medical Journal

In the absence of specific disease, fatigue of older persons arises principally from five basic causes:

- (1) Diminution of organic reserve particularly of the heart and circulation due to loss of vascular elasticity and arteriosclerosis;
- (2) Decline of endurance of mental and emotional effort, the basis of which is the sum of the many organic changes in the central nervous system accompanying the aging process;
- (3) Atrophy of disuse involving all systems of the body;
- (4) Loss of incentive, motivation and interest and
- (5) Decline of endocrine activity.

In attempting to control the fatigue of older persons, the physician is confronted with the paradox of a symptom that never can be entirely cured and yet almost always temporarily alleviated.

Fortunately much can be done by the physician to combat fatigue but he must be willing to devote enough time to the patient to determine which of the basic causes is predominately responsible. There is no rule of thumb regimen that is effective in all cases and clinical trial with periodic changes in therapy and prescribed patterns of living may be necessary.

Basically, fatigue can be alleviated:

- (a) By shrinking the individual's activities to the level where the symptom largely disappears, or
- (b) By measures that will tend to enhance endurance and tolerance to fatigue.

For a long time the approach to the problem of fatigue was thought to be simple. A brief history of the patient's mode of life was obtained with one objective in mind, to cut out something. It made little difference how little the individual was doing; if the patient was tired, something had to go. For instance, if the patient did nothing more than sit in a rocking chair all day long, he was no doubt advised to stop rocking and go lie down.

The enormous benefaction of rest, particularly as a therapeutic measure cannot be questioned. But too much of a good thing, or improperly applied, may be harmful. What surgeons have learned in the practice of early ambulation we are beginning to realize has application to many medical problems and particularly the problem of fatigue of the aged. Rest is not a universal panacea for fatigue, as thoughtful experience discloses over and over again. Many of these patients can be reduced to a vegeta-

tive existence and plied with sedatives and somnifacients and they are still tired.

What has been lost sight of is the fact that the pattern of modern civilized living, particularly in the United States, is specifically designed to avoid physical activity and stress. We have applied our enormous inventive genius and resources to the development and widespread distribution of labor-saving devices to the point where physical exertion is virtually eliminated. Young people are able to maintain their muscular and neurocirculatory tone in reasonably good condition through sports and play. As we grow older we tend to give up these things and with the help of labor-saving devices, including now electric golfmobiles, we begin to suffer rapidly and too early in life from atrophy of disuse. This brings with it, among other things, a loss of functional reserve of the heart and other muscles, including those of the vascular tree. As a consequence, the slightest added stress brings on undue fatigue.

Perhaps we have lost sight of some of the basic principles of physiology and biology that have application to this problem. Among these may be mentioned:

- (1) Functional capacities are maintained only through use;
- (2) Such capacities can be augmented, within limits, only through repeated stress;
- (3) Atrophy of disuse sets in rapidly and those capacities that are relinquished are soon lost;
- (4) Functional capacities decline with age but they will decline less rapidly if they continue to be used to their fullest extent!

With these thoughts in mind, it is evident that the most effective approach to the problem of fatigue of old age lies in prevention through the maintenance of an adequate neuromuscular reserve against stress. Fortunately, some degree of the same reserve can be regained at any time except where its loss is due to advanced organic disease. This may be accomplished by means of a regimen of graded exercise. The form of the exercise will depend on available resources and resourcefulness but every effort should be made to avoid drudgery and find some physical activity that is fun, and which the patient will be inclined to continue of his own volition. Golf, swimming, hiking, bicycle riding, gardening, badminton, and tennis are among the many pleasurable forms of activity that will serve the purpose.

Here too the rules of common sense are still applicable and too much exercise as well as too much rest can only defeat its own purpose. Along with exercise, the physician should see to it that the patient also obtains an adequate amount of sleep at night. If mental or emotional disturbances interfere with this, there is ordinarily no overriding reason why a good somnifacient should not be prescribed. A short rest at midday is of definite benefit in some cases, and almost all individuals can train themselves to sleep for half an hour if they will earnestly try.

At the same time the mental and emotional fatigue that comes at the end of a trying but sedentary day can be miraculously dispelled with a little physical exercise. It takes a particular charge of will power to undertake physical activity when fatigue is already present and all of nature seems to be crying for rest instead, or perhaps a drink. But over and over again it has been demonstrated that physical activity in such circumstances brings a degree of refreshment and renewed energy that nothing else can equal.

Undue fatigue of older persons occurs so much more commonly among those that are overweight that this circumstance warrants special emphasis. The remedy is obvious, easy to prescribe, but hard to take. A patient once told me, "What I need, doctor, is a will-power pill." In addition to dietary instruction, the importance of exercise should not be discounted, despite traditional handed down hearsay to the contrary. Its greatest value lies in its stimulating effect on endocrine activity, perhaps the thyroid in particular, and in overcoming the tendency to sleep and snooze too much which is such a common counterpart of obesity.

There can be little doubt that endocrine deficiencies contribute to the fatigue of old age in some individuals. This is particularly true during the menopause and in such cases the administration of estrogens are often of benefit. Whether or not a related change takes place in men is still a matter of dispute. Nevertheless, experience suggests that

small doses of testosterone are also sometimes of value in overcoming easy fatiguability of older men.

Thyroid extract is occasionally helpful, particularly where the basal metabolic rate is low and the serum cholesterol elevated, but otherwise it is more often disappointing than not.

The sympathetic amines, such as desoxyephedrine, Neo-Synephrine and Benzedrine have a potent effect in counteracting undue fatigue. As a general rule they should not be given until other measures have failed. They are, of course, counterindicated in hypertension, coronary and other vascular disease. Contrary to older pharmacological concepts, they are best administered in conjunction with a small dose of a sedative which permits the ergogenic effect of the amine to occur without the otherwise accompanying nervousness and sleeplessness. The sympathetic amines are particularly useful for fatigue in obese patients. Needless to say, patients receiving drugs for fatigue should be seen by the physician at regular intervals.

There is no reliable correlation between how hard a person works and degree of fatigue. If anything, fatigue of older persons is seen more commonly among those patients who do not have enough to do. Too often they feel that their life work is done and their fatigue has its origin in boredom, loss of incentive and interest. Over and over again when a crisis arises, or something of deep interest comes along, these individuals miraculously lose their fatigue.

It is of course difficult for a physician to prescribe an interest where there is no interest. Unfortunately "make work" programs often fail because they are undertaken half heartedly and the necessary compelling motivation is lacking. However, this should not serve as a deterrent, because a new and absorbing interest is the only real salvation for some of these patients. And when they find it, as some do, their symptoms disappear and they are given a new lease on life.

THIRTY-SECOND CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

HOTEL STATLER, HARTFORD

December 11, 12, 1957

The 1957 Clinical Congress will be presented on two days and all of the meetings will be held at the Hotel Statler in Hartford.

Two sessions will be held simultaneously in different auditoriums giving a broad selection of topics. Material in the fields of cardiac fluoroscopy, pulmonary edema, aldosteronism, panels on lung failure and pancreatic disease, clinicopathological conferences and other related subjects will be presented.

Registration admitting to all sessions will be \$5. Medical students, interns and residents will be the guests of the Congress, if properly certified.

MAKE A NOTE OF THESE DATES ON YOUR CALENDAR

PRELIMINARY PROGRAM
THIRTY-SECOND CONNECTICUT CLINICAL CONGRESS

HOTEL STATLER, HARTFORD

WEDNESDAY, DECEMBER 11, 1957

9:15 REGISTRATION

BALLROOM

9:45 CARDIAC FLUOROSCOPY (including mention of hazards)
John B. Schwedel, *New York, New York*

10:30 PULMONARY EDEMA
James V. Warren, *Durham, North Carolina*

BOSTON ROOM

9:45 ALDOSTERONISM
Frederic C. Bartter, *Bethesda, Maryland*

10:30 DISORDERS OF MENSTRUAL FUNCTION
Howard Ulfelder, *Boston, Massachusetts*

11:15 INTERMISSION TO VISIT TECHNICAL EXHIBITS

BALLROOM

11:30 CLINICOPATHOLOGICAL CONFERENCE
Stanley L. Robbins, *Boston, Massachusetts*

12:30 LUNCHEON

2:00 PANEL ON LUNG FAILURE
Robert E. Forster, *Philadelphia, Pennsylvania*
Edward A. Gaensler, *Boston, Massachusetts*
Max G. Carter, *New Haven, Discussant*

3:00 INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:15 Subject to be announced in November JOURNAL

4:30 SEMI-ANNUAL MEETING, HOUSE OF DELEGATES, CONNECTICUT STATE
MEDICAL SOCIETY

PRELIMINARY PROGRAM

THURSDAY, DECEMBER 12, 1957

9:15 REGISTRATION

BALLROOM

9:45 METABOLIC PROBLEMS OF POSTOPERATIVE PATIENT

Henry T. Randall, *New York, New York*

10:30 THE CHOICE OF TREATMENT FOR BREAST CARCINOMA

(Radical versus Simple Mastectomy and the place of Radiation)

Cushman D. Haagensen, *New York, New York*

BOSTON ROOM

9:45 DIARRHEA IN CHILDREN

Robert E. Cooke, *Baltimore, Maryland*

10:30 MANAGEMENT OF RESTLESSNESS AND SLEEPLESSNESS

John C. Krantz, Jr., *Baltimore, Maryland*

11:15 INTERMISSION TO VISIT TECHNICAL EXHIBITS

BALLROOM

11:30 CLINICOPATHOLOGICAL CONFERENCE

Edward A. Gall, *Cincinnati, Ohio*Max Taffel, *New Haven, Discussant*

12:30 LUNCHEON

2:00 PANEL ON MODERN TRENDS IN TREATMENT OF PANCREATIC DISEASE

Alexander Brunschwig, *New York, New York*David A. Dreiling, *New York, New York*Robert E. Cooke, *Baltimore, Maryland, Discussant*

3:00 INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:15 Program Arranged by Connecticut Chapter—American Academy of General Practice
Symposium—The General Practitioner—Hisplace in the Hospital and the Community

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To Aid the Mental Patient

The article, "Relations Between Mental Health and Public Health" in this issue mentions some of the methods that could be employed to provide a more coordinated attack on mental illness by Public Health and Mental Health personnel.

It appears that these two groups should join together in developing community programs to assist the released mental hospital patient in addition to programs of education, prevention and rehabilitation.

In Connecticut some plan should be devised to enlist the active participation of general hospital outpatient psychiatric clinics, local public health officers, and public health nurses with patients who return to their own communities after a period of hospitalization in the State's mental hospitals.

Coordination of community health resources and social agencies can be accomplished by personnel who provide direct services to patients and other people in trouble.

Smoking and Health

I. Smoking and Cancer

The suggestion of a possible relationship between smoking and certain diseases is, of course, not entirely new. In the medical literature of the early part of this century one finds articles on pipe smoker's cancer, though this was cancer of the lip usually assumed to be due to the irritation of the pipe rather than to the tobacco. There are also articles on tobacco as a cause of leukoplakia of the mucous membrane of the mouth and tongue and on the tendency of this lesion to undergo epitheliomatous degeneration. There are occasional reports suggest-

ing that smoking might be a factor in some cases of cancer of the larynx. It was not, however, until cigarette smoking became unusually prevalent in this country and widespread attention was focussed on the subject that intensive studies of the effects of smoking on health, particularly of cigarette smoking, have been carried out.* The study group referred to reports that at least 16 independent studies carried on in 5 countries during the past 18 years have shown a statistical association between smoking and the occurrence of lung cancer, not of adenocarcinoma but of the epidermoid and undifferentiated forms. Lung cancer occurs from 5 to 15 times more frequently among cigarette smokers than among nonsmokers and there is a direct relationship between the incidence of lung cancer and the amount smoked, the dangerous amount being tentatively estimated at over one pack a day. It is not claimed that this is the only cause of lung cancer and it is suggested that various other factors such as sex, nutrition, heredity, and particularly atmospheric pollutants may also play a significant role. It is obvious that additional research on many details is essential before we can offer the most intelligent prophylactic or therapeutic advice. The isolation and identification of carcinogens in tobacco smoke by animal experimentation, the nature of irritating atmospheric pollutants and possible methods of their removal, the possible role of psychic and hormonal factors, increased depth of ventilation through inhalation, and the presence of polycyclic hydrocarbons such as benzopyrene in tobacco smoke all need further investigation. The

*Smoking and Health. Joint Report of the Study Group sponsored by the American Cancer Society, the American Heart Association, the National Cancer Institute, and the National Heart Institute. Science, 1957, Vol. 125, page 1129.

fact that at least 50 per cent of cigarette manufacturers have adopted filter-tip cigarettes brings up the question of the efficiency of filters and a still unfinished report on this may be found in the *Readers Digest*.[†] Figures concerning the amounts of tar and of nicotine in plain and filter-tip cigarettes are there reported. They show that the efficiency of the filters varies with different makes, that the removal of tar is usually more efficient than that of nicotine, but that in some filter tips there is actually an increase in both. This be due to the fact that some manufacturers are using cheaper grades of tobacco in their filter-tip cigarettes. This brief survey clearly indicates that while cigarette smoke is probably a factor in the causation of cancer of the lung the subject requires more study.

G. B.

II. Smoking in Cardiovascular and Pulmonary Disease

There were suggestive observations covering this subject before the era of excessive cigarette smoking in the United States. The eminent German neurologist Wilhelm Erb noted early in the century in a study of obliterative endarteritis of the leg arteries: (1) that this was commoner in Eastern Jews than in other races, and (2) that many of these patients were excessive cigarette smokers. It was noted in the Medical Clinic of the University of Michigan that the smoking of one cigarette adversely affected the electrocardiogram in coronarians. The writer recalls a physician, a heavy cigarette smoker, who consulted him for intermittent claudication evidently due to spasm of the leg arteries, who recovered completely when he stopped smoking. The Committee listed in the editorial on smoking and cancer* recorded that at least three statistical studies indicated an association between smoking and decreased longevity in male smokers whose morbidity from cardiovascular disease was approximately double that of nonsmokers. However, the Committee states that at present there is no convincing evidence to indicate that smoking *per se* plays a causative role in cardiovascular disease. Many physicians believe that patients with coronary artery disease should not smoke and there is validating experimental evidence that nicotine perfused into the hearts of rabbits causes a diminution in coronary blood flow. Further observations on human beings are necessary. There are repeated, well confirmed observations that Buerger's disease, suspected by some to be a manifestation of allergy, is mate-

rially ameliorated by cessation of smoking and strikingly aggravated by its continuation. The role of smoking in gastrointestinal disease is so controversial that it merely needs mentioning as a possibility which demands much more intensive study. There seems little doubt that the inhalation of cigarette smoke may play a role in aggravating chronic bronchitis and pulmonary tuberculosis. One may sum up by saying that the abuse of smoking, particularly of cigarettes, is obviously detrimental in some forms of cardiovascular and also of pulmonary disease, but that much more investigation is needed before the whole story is known.

G. B.

Science, 1957, 125:3258, page 1129.

Surveying the Nation's Health

Reliable information regarding the occurrence of disease was formerly obtainable only through the scientific articles and books of medical investigators. Later in our medical history, public health agencies of local, provincial and national governments became interested in compiling and distributing such material. Voluntary health agencies have now for many years in the United States collected and disseminated statistical reports of the incidence of particular diseases. Increasing recognition of the fact that information on the state of health of the general population was either lacking or outdated resulted in the establishment of the United States National Committee on Vital Health Statistics in 1949.

The report of a sub-committee of this organization in 1953 entitled "Proposal For Collection of Data on Illness and Impairments—United States" became the basis for the new national health survey law. This survey is being conducted by the Public Health Service's division of public health methods. It consists of three parts: a continuous sampling of households on a national basis; a series of special studies to gather information of a type for which a household interview is not appropriate; and a series of methodological studies designed to improve the techniques of measuring illness and to check the validity of data collected in the interview survey and special studies.

The household interview, which is being done by the Bureau of the Census, began in the three thousand households which make up the national sample each month on May 5 of this year. There is at least one sampling unit in each State, and since a one time

[†]Reader's Digest, July 1957, page 33.

interview is planned, subsequent samples will consist of different households each month. Questions will be asked with regard to acute and chronic illness, time lost from work, bed confinement, accidents and injuries, dental care and hospitalization. Morbidity statistics will be compiled for the country as a whole and for the larger regional, metropolitan urban and rural areas.

Another approach to finding out what sorts of disease physicians see most often in their practices and what they do about them has been made by The National Disease and Therapeutic Index. This program was inaugurated in 1956 by an organization of specialists in medical epidemiological and market research with the support of four leading drug manufacturers. Although its primary purpose is to provide data as guides to research, new product development and marketing for the pharmaceutical industry, the results will be made available to the members of the medical profession on a regular basis. Advisory committees of medical educators and medical society executives provide guidance in the selection and preparation of the data to be released.

More than 1,400 physicians in twenty-seven selected areas throughout the United States, including fifty practicing physicians from the Hartford, New Haven area, have been among those reporting fully on each patient seen during a forty-eight hour period once each quarter. The first medical report, a preliminary analysis of "Neoplasms As Seen by Practicing Physicians," has recently been released.

From February 1 through December 31, 1956 the Index collected information on 91,801 patient visits. Of these, 2,536 were recorded with diagnosis of neoplasm or 2.8 per cent. Thirty-five per cent of the neoplasms were benign and 9 per cent of unspecified nature. The distribution of malignant neoplasm by site was in accord with what would be expected from other studies of the general incidence of malignant disease.

Forty-two per cent of all visits for neoplasms were for those affecting the genito-urinary system (including breast), but only 47 per cent of these were malignant. Only 20 per cent of the visits were for neoplasms of the buccal cavity and pharynx, digestive system and respiratory system, but approximately 83 per cent of these were malignant. Three hundred and sixty-six of the visits for benign neoplasms (more than half of the total) were for uterine fibromyoma and other benign conditions of the uterus and ovary.

About one-fourth of the neoplasm patients re-

ported underwent surgery. Forty-five per cent were treated with drugs. About the same proportion received drugs whether undergoing surgery or not. Sixty per cent of the visits of neoplasm patients were to the doctor's office. Seven per cent were seen at home and the remainder at the hospital. Of those patients seen at home, 95 per cent had malignant neoplasms, and of those seen at the hospital, 80 per cent. Only 30 per cent of patients seen at the office received drugs, but 60 per cent of those seen at the hospital and over 80 per cent of those seen at home received them.

General practitioners, internists and surgeons reported 72 per cent of the neoplasms seen by reporting physicians. Two specialists reported considerably more than their share of neoplasm cases, namely, urology and dermatology. Certified surgeons, who made up 10 per cent of the panel, saw 18 per cent of the neoplasms reported. Dermatologists and urologists, who made up only 2 per cent, each saw 7 per cent and 4 per cent of all malignant neoplasms. General practitioners, surgeons and gynecologists saw 32 per cent, 34 per cent and 36 per cent of their neoplasms in hospitals, but internists and urologists saw 52 per cent and 69 per cent of their patients in the same setting.

Among genito-urinary conditions, internists and urologists reported mainly malignancies. Gynecologists treated mostly benign conditions, while general practitioners and surgeons saw both with a larger proportion of benign conditions. Among lymphatic and hematopoietic neoplasms, general practitioners reported mainly malignancies, while dermatologists reported early benign conditions. For some inexplicable reasons, urologists reported seeing seven patients with neoplasms of the buccal cavity and pharynx and ten with neoplasm of the digestive system. The distribution of patients by sex and age was consistent with the fact that the diagnosis which was by far the most common was that of benign neoplasm of the female genitourinary tract.

These and other facts uncovered by this survey tend to confirm what has been long suspected by long experienced observers. In spite of the rapid increase in the number of malignant tumors of the respiratory system in males in recent years, the principal numbers of patients with neoplasm, which the general practitioner and surgeon, as well as the gynecologist and urologist, continue to see, have either benign or malignant neoplasms of the genito-urinary system.

SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

Hartford, Tuesday, September 24

HOTEL BOND, HARTFORD

Speakers: Mr. Charles Zimmerman, *President, Connecticut Mutual Life Insurance Company*
Mr. William Fenniman, *Vice President of the Connecticut Bank and Trust Company*
Mr. E. H. Heilman, Jr., *of the accounting firm of Knust, Everett and Cambria, and*
Mr. John H. Riege *of the law firm of Reid and Reige*

Subject: THE FINANCIAL AND LEGAL PHASES AND MEDICAL PRACTICE

Litchfield, Tuesday, October 1

TORRINGTON COUNTRY CLUB, GOSHEN

Dinner 7:00 P. M.

Business Meeting: 5:00 P. M.

Speaker: Mr. Philip H. Staats

Subject: COLORED MOTION PICTURES OF AFRICAN GAME

Fairfield, Wednesday, October 2

ROUND HILL CLUB, GREENWICH

Dinner: 6:00 P. M.

Business Meeting: 4:00 P. M.

Speaker and subject to be announced

New London, Thursday, October 3

NORWICH INN, NORWICH

Dinner: 6:30 P. M.

Business Meeting: 5:00 P. M.

Speaker and subject to be announced

Middlesex, Thursday, October 10

Dinner: 6:30 P. M.

Business Meeting: 4:30 P. M.

Speaker: Mr. Raymond Moeller

Speaker: ALL IN THE SAME BOAT

Tolland, Tuesday, October 15

OLD HOMESTEAD INN, SOMERS

Dinner: 6:30 P. M.

Speaker and subject to be announced

Windham, Thursday, October 17

NATHAN HALE HOTEL, WILLIMANTIC

Dinner: 6:30 P. M.

Business Meeting: 7:30 P. M.

Speaker and subject to be announced

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MEDICARE

The Dependents' Medical Care Program of the Department of Defense—MEDICARE—has been in operation since December 7, 1956 and in Connecticut has worked so smoothly because of the outstanding cooperation of physicians of the State and the prompt and skillful claim procedure of Connecticut Medical Service that it has become a fixed part of the medical care program in Connecticut with hardly a ripple. Up to August 30, 1964 claims have been paid to a total amount of \$123,522.69. On that date there were 300 claims still in process because of faulty or incomplete information.

If physicians will follow some of these suggestions, the processing of claims will be expedited.

1. Authorization card number. It is necessary in all cases of care given by physicians for some sort of authorization number to be given. If the patient claims she has no such card, she should contact her husband, requesting that he send her one or apply at the nearest military installation, or furnish the number from her driver's license or social security card.

2. Many claims being received have been signed by the sponsor instead of the dependent. A good rule to remember is that the sponsor never signs unless the dependent is a minor child or incompetent.

3. Date of delivery is necessary in all obstetric cases. And the patient herself must sign both certifications under section III, item 14, of the claim form. In cases of abortion or miscarriage, the week of pregnancy or the expected date of delivery must be given.

4. Anesthesia claims must show the actual amount of time required to administer the anesthesia; it is preferred that it be given in minutes, and must also include the diagnosis and the surgical procedure performed.

5. When an obstetric patient leaves a physician's care, i.e., if her husband is transferred to another duty station, please give reasons requested in section III, item 14, under "Additional certification required . . ."

6. MEDICARE does not pay for outpatient treat-

ment except in obstetric cases, fractures, dislocations, lacerations and other wounds. If a patient has been hospitalized and surgically treated, then follow-up x-ray therapy is ordered, the therapy will be paid for on an outpatient basis.

7. In every case where there is an allowable claim for outpatient treatment, the patient is required to pay the first \$15 of the physician's charges and this is indicated on the claim form in item 26. In these cases complete information as to the extent of care rendered should be given so that the claim can be properly evaluated.

8. Claims for services as assistant in surgical cases must be held by Connecticut Medical Service until the surgeons' claims are received. Claims for surgical assistants must include the diagnosis and the surgical procedure performed.

9. Item twenty-nine of the claim form—"Certification of Physician or Dentist." All claims must be checked in two places under this item, i.e., box "A" or "B" in the first paragraph, whichever is appropriate, and also either "A" in the second paragraph or "B" in the third paragraph whichever is appropriate. Claims must be checked and signed in box 31 on the claim form by the attending physician.

10. In claims for in-hospital medical care cases specific information should be submitted under item 22 of the claim form stating the dates on which the patient was visited.

11. Recent advice from the MEDICARE office in

Washington states "Physicians may add to their statements (DA 1863) those drug items which have been directly or indirectly furnished to the maternity patient. (Direct furnishing of drugs is: supplying drugs by the physician's office to the patient; indirect furnishing is: the physician writes a prescription to the patient but has the pharmacy bill him (the physician) for the drugs dispensed.)"

"A physician may also add to his statements the cost of laboratory work performed for maternity patients in his office or for work performed in a laboratory for which the physician has paid. If the laboratory is operated by a physician, the laboratory physician may submit a statement for service rendered indicating that he has rendered the service at the request of the attending physician."

Completed claim forms should be sent to MEDICARE, P. O. Box 755, New Haven, not to State Medical Society office.

Medicare and Influenza

1. GENERAL

The treatment of eligible dependents with influenza under the Dependents' Medical Care Program will be in accordance with the general provisions of the program. If hospitalization is not required, outpatient care by civilian physicians will be the responsibility of the patient. Where hospitalization is required, all the provisions of the program apply as for other medical cases.

2. IMMUNIZATION

Immunization for this disease is a procedure normally administered on an outpatient basis. Consequently, dependents, including those receiving obstetrical and maternity care, will not be eligible to receive influenza vaccine at Government expense, except as may be provided for in medical facilities of the uniformed services. A recent resolution of the State and Territorial Health Officers indicates that immunization for infants under three (3) months of age is not recommended. Therefore, influenza vaccine for newborn is not authorized at Government expense under paragraph 503d(2)(c) of the Joint Directive incorporated in the contracts for payments of physicians.

3. REPORTS

Cases will be coded under 481 (International Statistical Classification) and no special reports will be required. Physicians are expected to include Dependents' Medical Care patients in their usual required contagious disease reports to county and state health authorities.

Meetings Held During September

- 4—Poison Information Center Planning Committee
- 5—Board of Directors of Connecticut Medical Service
- 6—State Advisory Council, Connecticut Hospital and Public Health Center Construction Program
- 9—Committee on Eye Care
- 10—Advisory Committee to the State Board of Examiners for Nursing
- 11—Board of Directors, Connecticut Health League
- 12—Committee on Public Health
 - Committee on Third Party Payments
 - Committee on Hospitals
- 26—Council

Connecticut Hospital News

A proposal to use data processing machines on the monthly analysis of hospital service has been accepted in four Connecticut hospitals. These are Greenwich, Bridgeport, Waterbury and Danbury. The program, conducted by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, has been the topic of joint discussions between the Council on Professional Practice and the Committee on Hospitals of the Connecticut State Medical Society. The commission, which is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southwestern Michigan Hospital Council, uses punched cards and data processing machines to accumulate hospital service statistics. As hospital cases are discharged, summary sheets are prepared by the hospital's medical records department, and sent to Ann Arbor for punch card preparation. At the end of each month, an analysis of the service is prepared for the use of the medical staff records committee in each hospital.

PROGRESS IN CLINICAL MEDICINE

CURRENT MANAGEMENT OF THE SEVERELY BURNED PATIENT

IRA S. GOLDENBERG, M.D. and DONALD P. SHEDD, M.D.

Dr. Goldenberg, *Instructor in Surgery, Yale University School of Medicine, New Haven, Connecticut*

Dr. Shedd, *Assistant Professor of Surgery and Markle Scholar in Medical Science, Yale University School of Medicine; Associate in Surgery, Grace-New Haven Community Hospital University Service*

INTRODUCTION

With intensive research into many of the problems of modern medicine have come great forward strides in alleviating suffering and prolonging life. Infectious diseases are being conquered, degenerative processes better understood, and metabolic derangements identified and treated. Advances in traumatic surgery have been many, and complete rehabilitation of the severely injured patient into a worthwhile member of the community has become a reality. The many facets of medical progress have contributed greatly also to the management of the victim of severe thermal burns. Despite a more complete (although by no means entirely complete) understanding of the pathophysiological changes incurred after extensive thermal burning, the mortality rate remains high. Life can often be maintained now during the initial stages of burn shock, but sequelae such as infection have become a major problem, because patients are being kept alive long enough to face these hazards. It is the purpose of this presentation to review current thought in regard to the management of the burned patient emphasizing the problems arising during the acute phase. The treatment of superficial (first degree) burns will be dismissed here and efforts will be expended to detail only the management of deep second and third degree burns.

BURN SHOCK

Elucidation of the normal state in the human in regard to fluid and electrolyte compartmentation has laid the basis for an understanding of the alterations induced by extensive dermal burning. It is beyond the scope of this paper to discuss all of the changes

known to follow extensive burning, but certain important points should be mentioned. These form the basis for the various modes of fluid and electrolyte replacement which have evolved in recent years.

Rapid migration of a large quantity of protein-rich fluid to the area of the burn, as well as actual exudation into bleb fluid, creates a shock-like state in large surface burns. In addition, there is actual destruction of vast numbers of red blood cells. The magnitude of the early phase of fluid redistribution is directly proportional to the depth and the amount of surface area burned. Usually the patient burned over more than 20 per cent of the body surface needs parenteral fluid. Less severe burns may be managed by oral fluids alone.

Formulae have evolved from several medical centers to plan the fluid replacement in the severely burned patient. One of the most convenient to use, and one which in practice has been effective, is that of Evans.¹ Here the percentage of surface area burned is multiplied by the patient's weight in kilograms to arrive at a basic estimate in cubic centimeters of the amount of colloid fluid to be administered by venous catheter during the first 24 hours after the burn. An equal amount of electrolyte (normal saline or lactated Ringer's solution) is required as well as 1,200 cc. of 5 per cent glucose in water for insensible loss during the first post-trauma day for the average adult. The colloid material (replacing lost protein) should be pooled plasma stored at room temperature, which is believed to be safe from the danger of homologous serum jaundice. Whole blood replacement for destroyed red blood cells forms half of the colloid allotment. In the emergency situation a synthetic plasma expander may be used, but fluid plasma and whole blood should be given as soon as available. In the use of the Evans' formula, burns of more than 50 per cent body surface are calculated as though they were only 50 per cent to avoid excessive fluid administration. Normal saline may be used as the electrolyte solution, but it is an incompletely balanced fluid; a

more nearly physiological solution is lactated Ringer's.

The first 24 hours' fluid allocation should be administered at such a rate that one half is given during the first 8 post-burn hours, and subsequent quarters in each succeeding 8 hour period. This should be given at such a rate that urine output of 30-50 cc./hour is assured in the adult. An indwelling urinary catheter facilitates management of this aspect of the fluid balance. The fluid for the second 24 hour period consists of half the colloid and electrolyte volumes administered in the first 24 hours plus 1,200 cc. of glucose solution for insensible loss replacement. A recent investigation suggests that fluid problems may not cease 48 hours after burn trauma. Balance studies have demonstrated that water requirements are high after 48 hours, and that administration of large quantities of nonelectrolyte fluid may be important at this time.² Parenteral fluid usually will not have to be given after 72 hours, by which time oral intake commensurate with daily needs and losses can be started.

In the patient with less than 20 per cent burns, an oral mixture containing 1.5-2.0 Gm. sodium bicarbonate (1 level teaspoonful) and 3-4 Gm. sodium chloride (1 level teaspoonful) per liter of iced water may be used.³ Potassium may be added as fruit juice when one is sure that the urinary output is adequate. Quantities should be administered as calculated by the Evans' formula for parenteral fluid needs.

Of course, during the period of acute reaction to the burn, adequate sedation and analgesia should be administered to keep the patient comfortable. When respiratory tract burns are suggested, careful observation of the airway is indicated, with performance of tracheotomy at the first sign of obstruction. When frank tracheo-bronchial burns are present or when massive facial burns have been sustained, tracheotomy should be done before the patient develops airway problems.

Tetanus is still a not uncommon complication of severe burns, and all patients should be adequately protected against this possibility. Toxoid booster should be given when previous active immunization is known. If this fact cannot be ascertained, then tetanus antitoxin should promptly be administered (1500-3000 units).

LOCAL MANAGEMENT OF BURN

The local burn wound and its management have

been a problem for many years. To preserve life, save tissue, prevent infection, and maintain normal function are the primary aims of therapy. Local unguents were formerly widely used, but at present have little place. The management now is fairly well centered about "open" or exposure and "closed" or occlusive dressings. Each of these methods has its usefulness, but we, as well as others, have come to prefer the exposure treatment whenever it can be employed, and it is in this manner that the majority of our burn patients are managed. In certain instances the exposure method may not be preferable:

- (1) Circumferential burns of trunk or extremity.
- (2) Third degree burns of the hands.
- (3) Burns in patients who are to be transported to other institutions in the early days of their care.
- (4) Burns in those who are to be treated as ambulatory outpatients and who will continue working.

Gentle cleansing of the burned area with mild soap and copious amounts of warm normal saline is indicated immediately after the burn. Bits of easily loosened charred skin and clothing should be removed, but vigorous debridement is not indicated.

When occlusive dressings are employed, fine mesh petrolatum gauze is used next to the burn. Burns involving both anterior and posterior aspects of the trunk and extremities are problems insofar as the exposure method is concerned. One solution to this dilemma has been to place the patient supine on sterile absorbent dressing material such as that developed for use by the U. S. Army, so that the posterior burns are treated by pressure (by virtue of the patient's weight) while the anterior burns are exposed. The turning frames which have been devised in recent years also offer some advantages in problems such as this by allowing the patient alternately to have each side exposed.

When exposure methods are used, the patient should always be placed on sterile linen and all personnel should observe meticulous gown and mask technique, especially during the early post-burn days. After a satisfactory coagulum has formed, these precautions may be relaxed somewhat.

It has been felt by some surgeons that the exposure method cannot be used successfully in children, but such has not been our experience. Even the young child rapidly learns that the eschar formation is not to be touched and usually this aspect presents no problem.

About the 8th to 10th post-burn day the patient may be placed in a warm bath of normal saline to promote separation of the burn slough. The Hubbard tank has proved to be quite valuable for this purpose, the agitators aiding a great deal in mechanical cleansing. The objective at this time is the prompt removal of burned tissue to permit spontaneous healing of superficially burned areas and prepare other areas for skin graft coverage as necessary. Numerous methods have been proposed to achieve this objective, the cleansing of the burn surface, but the one we favor at the moment is some manner of wet dressings plus mechanical debridement. Very early surgical debridement has been suggested,⁴ but its exact place remains to be further evaluated. Early surgical debridement probably has a definite usefulness in burns of limited area, and in such instances as third degree burns of the dorsum of the hands.

Usually by the end of the second or third week the precise depth of the burns can be ascertained accurately, and at this time plans can be made for grafting third degree areas. Coverage of large weeping areas of granulation tissue is imperative to halt the great loss of fluid by this route, as well as to minimize as much as possible the obvious route of bacterial entry. Split thickness skin grafts are obtained with a dermatome and secured to the recipient area by sutures and/or dressings. In some extensively burned patients, complete graft coverage of the entire burned area may not be possible early, because of the limited amount of suitable skin on the patients' body to serve as donor site. One solution to this problem has been the application of fabric or plastic backed postage stamp sized split thickness grafts.^{5,6} By this method, limited skin can be used to cover a large area leaving gaps of granulation tissue between the grafts. These areas eventually become covered by epithelium originating from adjacent grafts. Recently we have expedited the procedure by eliminating suturing of the small skin grafts using instead sterile adhesive elastic bandage as suggested by Reese⁷ to hold the skin against the granulations. Pressure dressings are used outside the adhesive elastic bandage. Separation of the backing is easily accomplished in a warm saline bath after five to seven days. When the patient's available donor skin is very limited, postmortem homografts represent a solution to this problem. These serve admirably as physiological dressings, and although eventual slough occurs, the temporary decrease in

loss of fluid, protein, and electrolytes may be life saving. By the time the homograft is lost (2-12 weeks), the patient is better able himself to cope with the problems. Successive homografts may be used until such time as the patient's own skin is available as a donor. Methods have now been devised for preserving post-mortem homografts in a bank where the skin will be readily available if needed.⁸

If the patient survives the initial phase of shock without trouble, the ever present threat of sepsis becomes prominent. Septicemia is a principal cause of death in the severely burned patient.⁹ Although antibiotics are valuable in infection, they have not proven always to be effective in prevention or control of infections in the burned patient. Nonetheless, antibiotic therapy should be started as soon as emergency shock therapy is underway, and should be continued in adequate dosage for a prolonged period of time. Penicillin and streptomycin form a good duet of antibiotics for initial use. If the patient runs a febrile course in the face of these drugs, a wide spectrum antibiotic should be substituted. Cultures of the granulation tissue are helpful and sensitivity studies may aid in choosing the proper drug. Staphylococci are the commonest inhabitants of the burned areas, although a mixed flora usually develops eventually including coliform organisms. Resistance develops easily with these organisms, and the choice of drugs may rapidly become limited. The antibiotic should be continued through all grafting procedures and changes made as resistance develops or the clinical course warrants. Routinely cultures are taken at operation and the proper drug given as sensitivities indicate.

RENAL PROBLEMS

Renal failure is not uncommon when severe burns have been sustained. Acute renal failure may result from circulating breakdown products from the burned tissues, or may be due to the shock state immediately after the burn with the long term effects of temporarily lowered renal blood flow. In general, an indwelling urinary catheter should be placed so that a continuing estimation of renal function can be made. A decreasing urinary flow is indicative of renal failure, and if anuria finally supervenes, careful management of this problem is necessary.

In most patients renal failure develops during the 24 to 36 hours after burning. One must be certain that the anuria seen is not merely the result of

inadequate replacement of fluid early in the treatment phase. A provocative test such as the administration of a liter of 5 per cent glucose intravenously over a short period of time is in order. If the urinary output increases after this test, then one can feel that inadequate replacement is responsible and steps can be taken to remedy this deficit. If there is no response, then true kidney damage is probably present. Careful attention then must be given to fluid replacement schedules, and the patient should be treated as any patient with renal failure would be treated. Serum electrolyte levels, especially potassium, must be determined frequently, and if hyperkalemia develops, such means as ion exchange resins, peritoneal dialysis or use of the artificial kidney must be utilized.

LONG TERM REHABILITATION

The ultimate rehabilitation of the severely burned patient is difficult. Deficiencies fall into the general categories of cosmetic and functional. Disfiguring scars frequently will remain, and it may be necessary to embark on a long program of plastic surgery to restore normal appearance. Psychic suffering is great in these persons. Of greater importance, however, is the problem of motor deficit induced by scar formation and contracture. The full skill of a team of plastic surgeons may be necessary to manage such situations. It is most important, however, that restoration of function be carried out as completely as possible so that these patients may return as useful members of society.

CONCLUSION

A brief outline is given of one approach to current management of the severely burned patient. This is the program followed on the University Service at the Yale-New Haven Medical Center. At the present stage of knowledge many patients with extensive burns will not be saved because some of the physiological alterations following burns are irreversible. Nonetheless each patient should have the fullest effort expended in his behalf. Only when this is done can the high mortality rate be diminished. It is in the field of safety education that the greatest strides forward can be made. Most burns occur because of carelessness or ignorance. Eliminate these two factors and the need for a complicated program of management becomes less.

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Doctor Takes to Supreme Court His License Fight

A Los Angeles M.D. is carrying to U. S. Supreme Court his fight to prevent suspension of his license to practice. He was convicted of Federal income tax evasion and fined \$10,000. As a result, California Board of Medical Examiners ordered physician's license suspended for a year. His counsel contends that conviction of a felony, based on *nolo contendere* plea and not involving moral turpitude, proscribes disciplinary action under California Business and Professional Code.

The petitioner's legal brief notes that the judge, in passing sentence on the doctor, attributed his tax difficulties to inexperience in financial matters rather than intent to defraud the government, expressing the belief that no action would be taken toward suspension of his license. In an opposing brief, the California Attorney General argues that the board's disciplinary step was legal and appropriate. Supreme Court will decide at its fall session whether it will intervene.

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CMS ... Symbol of Health Care for Connecticut People

Governor Ribicoff and Mayor Richard C. Lee, right, are greeted by Dr. Thomas J. Danaher, CMS president, third from left, Dr. W. Bradford Walker, president, Connecticut State Medical Society, and, at left, Robert S. Judd, chairman of CMS Board of Directors.



Governor Ribicoff speaks at Ceremony for New CMS Building



Governor Ribicoff Commends Physicians at Ceremony for New CMS Building

Governor Abraham Ribicoff cited Connecticut Medical Service as "one of the great social advances in Connecticut history" when he spoke at a cornerstone ceremony for the new CMS general office building September 5 in New Haven.

The rapid increase of CMS subscribers, he declared, "means that nearly every other resident in Connecticut depends on CMS for assistance in meeting their surgical-medical-maternity bills." He commended physicians for founding CMS and noted the "overwhelming voluntary acceptance of the plan by the people of Connecticut."

Mayor Richard C. Lee, New Haven, told medical and community leaders in attendance that the building will be an important addition to the skyline of New Haven. He referred to the annual CMS report as evidence of a "firm and thriving organization" and praised enrollment increase to 1,000,000 subscribers as "a wonderful demonstration of the soundness and worth of your prepaid surgical-medical plan."

Robert S. Judd, chairman of the CMS Board of Directors, introduced Governor Ribicoff and Mayor Lee and invocation was conducted by Rabbi Robert E. Goldberg, Temple Mishken Israel, New Haven.

The ceremony was highlighted by presentation of documents and other memorabilia for enclosure in a cornerstone receptacle and the stone was set by Governor Ribicoff. The collection included the report of the State Medical Society's Committee on Prepaid Medical Care which recommended sponsorship of CMS; articles from the Connecticut State Medical Journal; a sketch of the building from the office of Douglas Orr; a photograph of the Montgomery homestead which was razed to provide space for the building; copies of CMS contracts, by-laws and annual reports; and a certificate from National Blue Shield Plans in recognition of enrolling one million CMS members.

The articles were presented by Dr. W. Bradford Walker, president of the State Medical Society; Dr. Creighton Barker, executive secretary of the Society; Dr. Henry A. Archambault, chairman of the CMS Professional Policy Committee; Miss Elsa Montgomery; Dr. William H. Horton, executive director of CMS; Dr. Thomas J. Danaher, CMS president; and Dr. Norman Welch, Chairman, Blue Shield Commission, representing Dr. Arthur Offerman, president of National Blue Shield Plans. Reverend C. Lawson Willard, Trinity Church On-The-Green, New Haven, delivered benediction at the close of the ceremony.

PUBLIC RELATIONS

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New Emergency Card for Physicians' Cars

A new emergency card for display in the windshield of a physician's car when parked during an emergency call has been announced by the American Medical Association and the National Police Officer's Association of America.

Similar to cards which have been used by some county medical associations for several years, the new four-by-nine-inch card is signed by Frank J. Schira, president, and Gerald S. Annenberg, secretary of the national police organization. Space is provided for signature of the local chief of police and the subscribing physician. Subscription price of the card is one dollar annually and it may be obtained by physicians directly from the secretary of NPOAA when their medical association has coordinated the project with the local police department.

A central registry of physicians who use the cards will be maintained at NPOAA headquarters. The purpose of the card is to provide a standard national credential which can be approved by all police authorities so that officers on duty can extend cooperation without question.

Samples of the card and pertinent information will soon be made available to local medical associations.

Asian Flu Information Program

An information campaign on public aspects of Asian influenza will be sponsored by the American Medical Association in those areas of the country in which outbreaks of the disease may occur.

One feature of the program will be a 55-second television announcement by Dr. David B. Allman, AMA president. If the expected epidemic strikes, the film will be distributed to TV stations. Until then, it will be kept under wraps. Radio announcements also will be distributed and release of all information will be coordinated with state and county medical associations in the affected areas.

Third Annual Medical Education Week Announced

The third annual Medical Education Week, nationwide tribute to the progress of American medical schools, will be observed April 20-26, it was recently announced.

Sponsoring organizations will include the American Medical Association, the Student American Medical Association, the Woman's Auxiliary to the AMA, the Association of American Medical Colleges, the American Medical Education Foundation, and the National Fund for Medical Education.

Local and state programs will be reinforced by national information activities through television, radio, newspaper syndicates and magazines. The national sponsoring organizations are planning to supply promotional aids to assist state and county officers to plan local observances.

During the 1957 Medical Education Week, medical societies in 32 States participated in the observance.

Advertising Council to Participate in Polio Program

Local polio drives will be implemented with advertising this fall as a program adopted by the Advertising Council gets underway.

The voluntary group of advertisers and businessmen recently announced acceptance of the vaccine campaign as one of its public service projects. A complete promotional program is being developed for newspapers, business papers, industrial publications, transportation and outdoor advertising, television and radio.

TV Information Reaches Mass Audiences

Millions of American viewers, many of whom knew little about medical progress prior to the present era of visual information, are now receiving

regularly messages through films aired by the American Medical Association.

A brief extract of the 1957 President's Inaugural Ceremony was sent to newscasters across the nation. Reports indicate that nearly 17,000,000 viewers heard Dr. David B. Allman's remarks over 179 telecasts in 143 cities. The AMA's new 30-minute motion picture, "Even For One" (which tells the value of a doctor's judgment), has been seen by 9,500,000 since its release to television stations in March. The program has been used 167 times in 159 cities.

Three New Pamphlets

Three new medical pamphlets for public distribution will be made available by the American Medical Association this fall.

As yet unnamed, the publications are being written to cover the following topics: Free Choice of Physician—why it is important for the patient seeking thorough and sound medical care to retain his right to select his own personal physician; Today's Cost of Medical Care—an illustrated brochure explaining that, while general costs of living have skyrocketed, the public's medical fee dollar buys more and better care today than twenty years ago; The "Judgement" in Medical Practice—under a physician's care, the patient receives more than the tangible benefits of medical knowledge and training—he is the recipient of discriminating judgment in application of the art of medicine.

Doctors in the Draft

It is now official, and in writing, that physicians and dentists under age 35 and otherwise potential inductees of Selective Service are not to be drafted. Operations Bulletin 181, signed by Selective Service Director Lewis B. Hershey, directs local boards to issue no orders calling up doctors for physical examination. And in cases where examination has been given and subject classified available for military service, induction orders shall be postponed indefinitely.

Since expiration of doctor-draft law last June 30, it has been assumed that Defense Department would take steps to prevent induction of any doctors as regular registrants. The Hershey directive was issued at request of Department of Defense. The indefinite deferment which it grants applies to registrants holding degree of bachelor of medicine, as well as M.D.'s, D.D.S.'s, and D.M.D.'s.



Dr. William R. Wilson Appointed to Connecticut Medical Examining Board

Governor Ribicoff, on the recommendation of the president of the Society, Dr. Walker, has appointed Dr. William R. Wilson, New Haven, to be a member of the Connecticut Medical Examining Board to serve the unexpired term of the late John H. Bumstead.

State law provides that in the event a vacancy occurs on the State Medical Examining Board, a recommendation for a successor shall be made by the president of the State Medical Society and not the Society as a whole. After consultation with other members of the Board, Dr. Walker recommended the appointment of Dr. Wilson. It is the first time that a pediatrician has been a member of the Medical Examining Board, a suggestion that was made by the pediatricians of the State a few years ago.

William Rives Wilson, M.D. was born in Sturgis, Kentucky, July 1, 1898, received his A.B. from the University of Kentucky in 1921 and his M.D. from Johns Hopkins School of Medicine in 1925. He was an intern in medicine in the Baltimore City Hospital, 1925-1926; following this he was intern, associate resident and resident in pediatrics at the New Haven Hospital. From 1927 to 1929, he was a staff physician at St. Louis, Missouri, Children's Hospital; then Acting Adjunct physician in the Children's Medical Division at Bellevue Hospital, New York City; and assistant in pediatrics on the faculty of

the College of Physicians and Surgeons, Columbia University. Dr. Wilson came to Connecticut in 1930 where he has been in the practice of pediatrics since that time except for the period during World War II when he served as a Commander, MC, USNR. He was certified by the American Board of Pediatrics in 1936 and is now attending physician at the Grace-New Haven Community Hospital, the Hospital of St. Raphael and the Griffin Hospital, Derby, and associate clinical professor of pediatrics in the Yale School of Medicine.

Function of Blue Shield Plans

The *Michigan State Medical Journal* for June devotes considerable space to a series of presentations on Michigan's Blue Shield Plan—its accomplishments, current problems, future goals and responsibilities. This special Blue Shield edition of the State Journal has become an important annual event for it serves to bring the doctors of Michigan up to date on matters of importance to the progress of their Blue Shield program.

This year, the papers on Blue Shield appearing in the *Journal* were those given at a special meeting of the Michigan State Medical Society's House of Delegates held earlier this year. Among the papers featured in the special edition were those presented by Dr. L. Fernald Foster, president of Michigan Medical Service; Dr. George W. Slagle, president-elect; and J. C. Ketchum, executive vice president of the Plan.

Dr. Foster described in detail the development of Michigan's Blue Shield Plan and emphasized its essential role in serving the needs of the public and profession for a mechanism whereby medical care could be financed on a basis compatible with the interests of medical practice and the public interest. Citing the economic and social trend of the late twenties and early thirties which gave rise to the need for developing a mechanism to help people pay for needed medical care without the imposition of governmental control, Dr. Foster pointed out how the Michigan Medical Society created its own program to meet the problem.

Dr. George W. Slagle's address, as published in the *Michigan Journal*, called on the profession to join together in solving the problems confronting it. He stressed that medicine must present a united front and shape a total effort in charting the future of its voluntary medical care prepayment program.

Dr. Slagle insisted that the future of Blue Shield depended on a highly developed system of communication capable of creating an informed profession sensitive to the needs and problems to be met in developing Blue Shield in accordance with public need and demand. Dr. Slagle emphasized this need when he said, "Today there is a greater need for a united, forceful and informed profession than ever before."

He continued, pointing out that the profession "must become a fighting unit to keep the Doctors' Plan truly all doctors' plan, to make it the best, and to give service to our subscribers so that the public will prefer the Doctors' Plan to panel practice, organizational practice, governmental practice or any other scheme involving third party control."

Jay C. Ketchum, reviewing a considerable number of the important problems and developments affecting the future of voluntary prepayment, set forth the urgency of carefully evaluating every factor involved in charting the future course of the Blue Shield Program. What does Ketchum see at stake in the future? He put it this way: "Failure of voluntary means for providing health care can only result in compulsory methods being employed. The people have been told that voluntary methods can provide the answers. The voluntary plans have shown great ability so far and have led the people to expect more and better results. If the medical profession wants Blue Shield as its method in preference to other alternative attempts, and, if Blue Shield is inadequate for current needs and requires change or expansion to make it adequate, then Blue Shield can do the job, but—it can do only what the Profession wills it to do; it can be only what Medicine wants it to be."

Essentially, the national organization of Blue Shield Plans functions in the same manner as a trade association. Its affairs are governed by a board of directors known as the Blue Shield Commission. The composition of the Blue Shield Commission is of special interest because it reflects the degree to which the medical profession is represented. Each Plan District, of which there are eleven, elects two Commissioners, and, of these, one must be a doctor of medicine and a member of a Plan board. Nine Commissioners-at-large are also selected, and, of these, six must be doctors of medicine. Three of the Commissioners-at-large are appointed by the American Medical Association and the others are elected

by the member Plans at their annual meeting. At present, 20 of the 31 Commissioners are physicians.

Of what importance is the national organization of the Blue Shield Plans and what purpose does it serve? The By-Laws of the organization provide that the association shall undertake and promote research and statistical services; consultation and information services; public education activities and coordination and reciprocity arrangements between Plans relating to subscriber service.

Specifically, the functions performed by the association in the interest of member Plans presently includes programs and services related to nearly all aspects of Plan management and administration. Annual conferences on enrollment, professional relations, research and actuarial science, office management and public relations are organized for Plan representatives. These meetings are planned to keep Plan personnel well informed on all phases of Plan administration and to encourage a constructive exchange of information and experience among all Plans.

The association also conducts intensive research studies and provides the results of such studies to Plans to assist them in shaping their enrollment and product development activities in conformance with the current trends in public demand and economic conditions.

Periodic bulletins and special reports on all phases of Plan management and administration are distributed to Plans as part of an informational program to foster continuing improvement in Plan operations.

The association also conducts continuing programs of publicity, professional relations and national advertising activities to extend the effectiveness of local Plan efforts in these important areas of promotion. For example, a national advertising program appearing in *Reader's Digest*, *The Saturday Evening Post*, *Time*, *Newsweek* and other national magazines is presently carrying the story of Blue Shield to millions of readers month by month throughout the year.

Contacts with national business and trade associations including the American Medical Association, medical specialty organizations and governmental agencies are maintained in behalf of Plans to promote their interests, develop activities and extend the acceptance of the Blue Shield Program nationally.

All of the activities of Blue Shield Medical Care

Plans are planned with the guidance of committees appointed by the Commission and the Conference of Plans. The implementation of all services is accomplished by a staff experienced in Plan management, research, public and professional relations, statistics and actuarial science.

Funds Awarded for Research and Sewage Plant Construction

Although the funds have been available for only six weeks, Public Health Service already has granted most of this year's money appropriated for two programs, to aid in expanding medical research facilities and to help in construction of sewage plants.

Research Construction money was voted for the second year of a three-year program, designed to stimulate expansion of health research facilities by having the federal government pay up to half the cost of building and equipment. This fiscal year, as last, Congress voted the full \$30 million authorized. First awards for this year number 100; and go to 77 institutions, including hospitals, universities, research institutes and schools of medicine, dentistry and public health. The grants total \$26.5 million. Institutions and agencies receiving grants of half a million dollars or more include: University of California at Los Angeles, University of Connecticut, California state department of public health, University of Georgia, Chicago Medical School, University of Illinois, Purdue University, Tulane Medical School, University of Boston, Harvard, University of Michigan, Wayne University, University of Minnesota, Washington University, New York Memorial Center for Cancer & Allied Diseases, Western Reserve University and Hospital, University of Pennsylvania, and Women's Medical College of Pennsylvania.

Since the start of the research grants program July 1, 1956, a total of 257 formal applications and 81 supplemental requests totaling \$114 million have been received. In addition, 83 institutions have indicated their intention to apply for \$38 million.

Sewage Plant Grants totaling \$38 million, out of a \$50 million appropriation, also have been awarded. To the federal money communities added almost \$129 million, indicating total expenditures of \$167 million on the projects. Average U. S. grant was about \$85,000, average community benefited had a population of 22,300.

Special Article

UTILIZATION OF RESERVE MEDICAL PERSONNEL DURING TOTAL WAR

H. H. TWITCHELL

WHAT do we mean by "total war?" There are many ideas and beliefs concerning what a next total war will be like. The thoughts about how such a war will be conducted and just what will happen, is limited only by the number of people you talk with, and the number of articles you choose to read. Our most talented and most experienced people, in this field, do not completely agree on what will happen.

I believe that we can afford to take a good, honest, broad-minded look at what can happen. We must not play ostrich and hide our heads in the sand! Let us be honest with ourselves.

PLANNING OUR MEDICAL RESOURCES FOR WORLD WAR III

If we had a World War III in which nuclear weapons are used, the expression "Hell on Earth" will be a minimizing description! I think we all know this, but I doubt that we are really admitting it to ourselves. In fact, I think that we are cheating ourselves terrifically. All of us, and by that I mean those of us in the military services, and the Federal Defense Administration, have as a part of our mission the planning for and the use of our medical resources in the time of war. Those not connected with these agencies have a major interest too. It is your life, the lives of members of your family, and the life of your nation with which we are concerned!

In such planning, I am sure we have figured out many times by many formulae the total number and various kind of casualties we will suffer if our country is attacked with nuclear weapons. The figures are appalling, no matter what system you use. In fact, they are so appalling when estimated for any one small chosen area, that when we consider the same thing has probably happened in fifty or one hundred other areas of the country, we are emotionally unable to understand just what it means! We cannot see the forest for the trees! Consider again, for a moment, the terrific impact on local medical capabilities of the various individual and comparatively small disasters which have occurred in widely scattered parts of the country. You know

The Author. *Brigadier General USAF (MC)*
Surgeon

SUMMARY

The possibility of another world war must not be evaded but there should be systematic planning for the use of our medical resources in such an event. Many difficulties will prevent proper care of the critically injured. First aid rendered efficiently and rapidly will be the first prerequisite in caring for masses of injured.

The medical aspects of catastrophe are divided into (1) First Aid and Confusion, (2) Definitive Care and Survival, and (3) Medical Rehabilitation. These are discussed in some detail. The medical profession must be organized rapidly and early and in addition there must be organization and training of dentists, nurses, and other paramedical personnel for the emergency. An adequate medical program for another total war can be realized only through expansion of our present military capability.

about some of them first-hand, and in general you know how terrific the medical demands were. I believe that your practical experience has probably made you far more appreciative of the problem than are most groups. You also know that the overall handling in some of these situations was not of the high professional standard that we have learned to expect. Consider just how critical the medical situation will be if the severity of each of these disasters were increased 1,000 times. Consider that this same type disaster has occurred in fifty to one hundred of our other major population centers almost simultaneously. Gentlemen, this is when we begin to hide our heads like ostriches!

Ordinarily, we do not really consider it much beyond the point of just how it would effect each one of us individually. During the first few days of a nuclear attack, we as physicians will have to be thinking and acting in a manner for which we are neither training, nor adequately planning, at the present time.

The immediate problem, at that time, will be a tremendous workload of emergency first aid care—and national reorganization in order to permit the greatest possible military retaliation. For our military forces to retaliate, the nation must approach our casualties with the view of getting the greatest number of people back to work in the shortest time possible! Gruesome as it sounds, it means that many critically injured people will die for lack of highly specialized, time consuming procedures, that we will not be able to perform because of lack of proper space, lack of proper material, and probably most of all, lack of properly trained people.

I say "lack of space" because it seems obvious that an undetermined number of our hospital facilities will be destroyed. I say "lack of material" because no one can predict just how much of the presently stored medical supplies may be within the radius of the destructive forces of the nuclear explosion. I say "lack of properly trained people" because nuclear detonation will be no respecter of personalities who are within the reach of its devastating potential!

DIFFICULTIES INVOLVED

You, as a group, are well acquainted with some of the major difficulties that we will encounter. Communications will be nonexistent, or greatly overloaded. Transportation facilities that remain will be tremendously overtaxed. Sources for electricity and gas, which are usually accepted as always present, may not be available for days. Water supplies may be interrupted or contaminated to the extent of nonusability for days, or even weeks. Under these conditions, we cannot hope to practice medicine under the concepts in which we presently work.

The communities in this area are far ahead of most parts of our country. This is evidenced in the article "Connecticut Hospitals Review Flood Lessons" by Albert F. Dolloff, in the September issue of *Hospitals*. His approach is realistic, and bears direct reference to the actual problems that were and will be encountered.

Today we think in terms of very highly specialized professional care involving one patient. We think and practice medicine, as we should, with the viewpoint of being able to pull patients back from the very grip of death. We take great pride, and we should, in our advanced technical knowledge which permits us to reactivate the heart of the patient in cardiac arrest. These things we can do when we

have ample available ancillary support, and when we have abundant assistance to provide great amounts of detailed postoperative care. That is the way to practice medicine in peacetime. Every patient can and should benefit from every bit of technical knowledge and capability available to our profession. In everyday peacetime practice, we can consider the individual. In case of nuclear attack, we will have to consider the masses, not the individual! The very existence of our lives and our country will depend upon the ability of the medical profession to return the greatest possible number of the people back to work, in the shortest time possible.

FIRST AID TREATMENT

Rapid, efficient first aid treatment for the masses of injured will be the medical mission for the first few days after all-out nuclear attack. We are going to find it difficult to change our concept of the practice of medicine and leave the critically injured to die when we know that if we had the facilities, material, and people, we could probably save them. I believe that this sudden change of concept may be one of our greatest problems! I know we are not emphasizing this concept enough in our training for all-out war. Why not? We, you and I, are playing ostrich, and will not accept this concept during peacetime! Deep down in our hearts we know it is a true concept, and the only realistic one by which we can successfully treat mass casualties in the event of nuclear war.

Earlier in this paper I have implied that lack of people qualified to render high quality first aid care would be one of our biggest problems. Not only do we lack people, we lack full organization of those people presently available. I believe that the best potential of saving the greatest number of lives, in a catastrophic situation like this, will be the ability of every individual to perform reasonable first aid for himself and for his buddy! With the majority of the population of the United States trained in this way, it is easy to conceive of the decreased demands on our professionally trained people to render care for the minor injuries. The more we can release the highly trained personnel from the requirement to treat minor injuries, the more time they can devote to the care of the seriously injured. I have read that first aid courses are required instruction in the public schools of Russia. It would seem that such courses would be a major step forward in medical preparedness of this country. Not only is it a good project for war

time readiness, it is training that may be of life saving value to thousands each year during peacetime.

Let us consider the medical aspects of catastrophe in a broad way. What may actually happen if this nation is faced with a surprise attack by nuclear weapons? It is my opinion that, medically, we will have to go through three distinct phases. First, a period of First Aid and Confusion. Second, a period of Definitive Care and Survival. Finally, a long period of Medical Rehabilitation for enormous numbers of casualties.

PERIOD OF CONFUSION

As a result of any surprise attack of major proportions, there is bound to be a certain period of confusion—in spite of excellent planning and many practice alerts. It is impossible to make practice alerts sufficiently realistic to the majority of people. How long the confusion will last and how severe it will be cannot accurately be predicted. It will exist. The length and severity can be reduced only by adequate and realistic training. During this initial period of confusion, what are all of us as professional people going to do? First—we are human—we are going to be worried about our families. What each one of us does along that line can only be answered by the individual at the time. Second—each professional person will be surrounded immediately by people in need of help. It is probable that at that particular time, material with which to provide care for more than a few will be lacking. Obviously, in peacetime, one just does not carry enough medical supplies to treat the injuries of an entire neighborhood in a disaster situation. Everywhere demands will greatly exceed capability. Third—all the time that we as individuals are doing all we can to take care of those immediately around us, we will be thinking about the big overall plan and our individual part, which probably should be to go to a specific place and be part of an organized team—be it a Civil Defense team, or a specific mobilization assignment as part of a military team. We must remember that getting from any one place to another, or communicating with others, is going to be exceedingly difficult.

I believe that moderate confusion will remain evident for at least two or three days, unless we improve our emergency plans and practice very realistically those improved plans. When communications are reestablished, means of travel improved, we will pass into what I call the second major phase—

that of Definitive Care and Survival. Early in this phase, and as rapidly as we can overcome confusion and establish communications, I am sure that we will put into action the various military plans, and Civil Defense plans, that will group our limited numbers of professional personnel into the teams that are so vitally necessary to produce the best possible medical results. Experience has shown that organized medical teamwork and individual cooperation is of the greatest importance in the rapid professional solution of any disaster situation.

DEFINITIVE CARE AND SURVIVAL

It appears to me that it is at this point in my so-called "second phase" that members of the Reserve components become tremendously important cogs in the military medical machinery. Proper organization and utilization of our medical capabilities will alleviate suffering and save lives by definitive type medical care.

At the same time the capability to continue to exist may be a terrific problem, for example—are our water supplies contaminated? How? What can our ancillary professional people do to correct this? Are we planning and training enough people for this phase of our problem? I doubt it! I'm afraid we are apt to think in terms of the present adequate availability of working stills, of large flocculation beds, and of similar up-to-date mass production items. One question alone indicates how these problems can be compounded a thousand times, "what will be obtainable as source energy to run the technical equipment available?" How long will this period last? I would not hazard a guess. It depends upon how successful the enemy has been in his surprise attack, how effective our defenses have been, how effective our retaliation has been, and how well we are prepared and trained to meet a disaster of the proportions we can anticipate from a nuclear attack.

MEDICAL REHABILITATION

The third phase is that of Medical Rehabilitation. This will run concurrently with the overall rehabilitation of our nation. To me, the nature of this problem is such that it involves policies and principles beyond the scope of this group at this time. We can only say that the time, the personnel, the facilities, and the cost that will be required are of a nature that will encompass the entire medical profession, and even the political structure of the nation. The present problems of the Veterans Administra-

tion will be considered small when compared to such a problem as this.

We have talked at length on the concepts of total war. We have talked about the effects on the masses of people. In the event of a World War III, I am sure each one here, whether in the Militray Reserve or not, will be interested directly or indirectly in the problem of organization of our nation's total professional capabilities.

ORGANIZATION OF THE PROFESSIONS

There is no doubt in my mind but what much has been learned about organization and mobilization of professional people as a result of our previous wars, and the Korean incident. Experience taught every one the weak links in the chain. In each successive incident, utilization of professional personnel was definitely improved. There is every reason to believe that if another war comes, still further improvement will be evident. I am sure that the system will never be so perfect that everyone will be called just when he wishes to be, or to go just where he wants to go, or do just exactly what he wants to do. It would be impossible to match people and jobs that well in a national emergency with requirements far exceeding capabilities. In arriving at plans for the best possible use of professional personnel, in case of war, I am sure that all planners—Army, Navy, and Air Force, and Federal Civil Defense, are cognizant of two major factors which definitely affect utilization. These two factors are Requirements and Capabilities. I would like to crudely compare these two factors to the making of a pie. The first factor is requirement for professional personnel to meet the medical problem. The medical problem is adequate medical care for the massive number of casualties that will occur if portions of our total population of 165 million people are subjected to nuclear attack. These medical requirements are the ingredients that make a theoretical pie of tremendous size. Capability is the second factor. The capability to meet the problem rests on the shoulders of some 218,000 doctors, 83,000 dentists, 555,000 nurses—plus the other paramedical personnel now trained to support professional care. If we take this entire professional source and consider them as available ingredients of the theoretical capabilities pie—our product, in comparison to the requirements pie, would not be quite so big.

If we think about it honestly, it is pretty obvious

to all of us that in case of a major war in which nuclear weapons are used, our country is going to be very, very short of medical capabilities. Realizing this, I then raise the question, "Should we as doctors exert more of our efforts toward training more people in First Aid care, in order that we can use our limited capabilities in the best possible manner?" To treat large numbers of casualties, our experience in Korea taught us that there was much to be learned by the majority of doctors who saw the wounded first. We learned that if the large numbers of patients were going to arrive at hospitals in a condition that would permit definitive care, they had to have had an excellent type of first aid treatment—early! I recommend that all of us, in our training program for Reserve medical personnel, place more emphasis on quality first aid treatment. This same teaching program applies equally well to the Civil Defense Program. Through our personal interest and position as doctors, we can stimulate interest in such first aid training throughout the general public, and thereby probably save many many lives.

Based upon previous mobilization experience and certain concepts of total war, I am sure that it is justified to say the requirement for rapid, early organization of all medical professional personnel will be a must. I am sure that medical manpower will not be wasted, that every physician, dentist, nurse, and all other paramedical personnel will be utilized to their utmost capability, and probably far beyond the presently accepted level of daily work load! Reservists will be utilized in special medical units to support certain military operations. Reservists will be utilized to man hospital type units in support of geographical areas of both military and civilian populations. Controlled medical organization can and will be the life line by which this nation will recover.

In a time such as we have visualized here, the biggest portion of the answer to recovery is organization of our medical capabilities. Such organization is inherent in the Medical Reserve forces. As individuals, during the first few days, before you can become identified with a specific job in a specific organization, you may be called upon to do most anything in the field of medicine to save human life. The internist, the psychiatrist, the pathologist, the radiologist, the dentist, the veterinarian, will all be working around the clock, rendering first aid care to burn and blast wounds. In many cases this profes-

sional care will be completely foreign to their daily peacetime practice. As organization becomes effective, professional personnel will work into the specialized spot for which they are trained. As we go into rehabilitation, I am sure that no stone will be left unturned in the effort to utilize every individual in the field where he has had specialized professional training. Shortages in every specialty will be so great that highly selective assignments are a must. Those without specialty training will find themselves in great demand for the major supporting roles of the specialist in this show. It will not be entirely a specialist show. Those in supporting roles will share fully in the final results.

In this talk I have tried to assume somewhat the role of the "dog in the manger." We have emphasized the more serious side of the picture that ordinarily we do not think about. We have tried to point out the fact that if there is total war, the medical problems may be far greater than most of us are usually willing to acknowledge. We have pointed out certain lack of medical potential. We have indicated areas in which I think our training is weak because we may be overlooking the important initial phase of nuclear war. The trend of medical training today is toward specialization. Immediately after nuclear attack the need will be for superior first aid care. Without this element we may not exist to the time when the need for specialized care becomes necessary. We have indicated the great importance that organized medical forces will play. If I have caused you to consider that the potential problem may be greater than we usually think, and that there is room for each of us to do just a little more toward preparedness, then I will feel that I have accomplished my mission.

I strongly urge that you as an individual doctor, and we as a united group of doctors with background experience in handling large numbers of casualties, consider methods of training many people to do first aid tasks that must occur in any situation when large numbers of casualties may exist. If such training is successfully accomplished and properly utilized, then each of you, as a physician, can better apply the specialized knowledge you have acquired here today.

Only through great expansion of our present military medical capability, can we provide an

adequate medical program that will be the backbone of support and recovery to both the military and civilian components of our nation, in case of another total war. I recommend participation in the Air Force Medical Program as a means of self improvement and organized support of our nation in the event of war.

Scientific Panel Discusses Problem of Food Additives

For two days a panel of 15 scientists discussed problems of food additives before the Health subcommittee of the House Interstate and Foreign Commerce Committee. Among the major points they brought out:

USEFULNESS OF ADDITIVES

There are certain technical justifications for them; they reduce waste, make foods more attractive to consumers, often aid the manufacturer in processing and shipment, they should not disguise a product or deceive the consumer, or reduce nutritional values in any important manner.

SAFETY PRECAUTIONS

Any chemical handed to public for any use whatever should be pre-tested. Every additive is different and requires own testing. If prospective market is small, expensive testing not in order, but product then not given general release. The government should not insist on uniform testing, which would stifle scientists' constant search for newer and better procedures. Food scientists, operating in teams of diversified training, have accepted responsibility to examine and re-examine testing procedures.

ADDITIVES AND CANCER

Attempts to trace a relationship between additives and human cancer were described, but no relationship has been proven. A proposal for pre-testing all chemicals used in foods and banning any that cause cancer in animals was called too drastic, as the same carcinogens do not necessarily carry cancer in both man and animals; likewise rejected was a suggestion that all food dyes be tested, because this operation, it was said, would occupy all the time of all the qualified scientists in the country for 25 years.

COMMITTEE ON MEDICAL CARE OF VETERANS

George A. Buckhout, *Chairman*, Bridgeport

Francis D. T. Bowen, Hartford
Joseph J. Bruno, New Haven
Francis J. Kalamán, Norwalk
Andrew P. Owens, Bridgeport

Samuel B. Rentsch, Derby
Roy V. Sanderson, Winsted
Benjamin M. Shenker, Middletown

NEW CONNECTICUT FEE SCHEDULE FOR MEDICAL CARE OF VETERANS

Negotiated by the Committee on Medical Care of Veterans

Effective July 1, 1957

I. GENERAL

A. This fee schedule and approved amendments thereto is part of the agreement between the Veterans Administration and the Contractor.

B. Fees for services listed herein are the maximum that may be authorized by Veterans Administration field stations. By special report, exceptions to listed fees may be proposed in individual cases as provided under the terms of the contract.

II. CONSULTATIONS AND EXAMINATIONS BY SPECIALISTS

A. Examinations by specialists are differentiated from formal consultations by specialists. Fees for formal consultation will be allowed only when consultation rather than examination by a specialist is specifically authorized.

B. As a general policy, specialists will only be authorized to conduct examinations covering their particular specialty. If, however, a specialist is authorized to conduct a complete physical examination concurrently with an examination covering his specialty, his fee for the two concurrent procedures will be the greater fee plus one half of the smaller fee, or one and one half times the fee listed in the schedule when the same amount is shown for each service.

C. The foregoing is not applicable to laboratory or x-ray services. Fees for these services will be in accordance with the actual number of services performed at prices listed in the fee schedule for each item, except as otherwise specified.

III. STANDARDS FOR DESIGNATION AS SPECIALISTS IN PSYCHIATRY

A. Certified in Psychiatry by American Board of Psychiatry and Neurology; or

B. Specialist not possessing specialty board certificate:

1. Completed three years of formal Residency Training in Psychiatry acceptable to the American Board of Psychiatry and Neurology and at least 50 per cent of practice devoted to Psychiatry; or

2. Completed three years of formal Residency Training in Psychiatry acceptable to the American Board of Psychiatry and Neurology and recognized as specialist in Psychiatry by the local or State Medical Society where he practices; or

3. At least four years' experience in the practice of Psychiatry (which may include time spent in Psychiatric Residency Training) and at least 50 per cent of practice devoted to Psychiatry; or

4. At least four years' experience in the practice of Psychiatry (which may include time spent in Psychiatric Residency Training) and recognized as specialist in Psychiatry by the local or State Medical Society where he practices.

IV. STANDARDS FOR DESIGNATION AS SPECIALISTS IN NEUROLOGY

A. Certified in Neurology by American Board of Psychiatry and Neurology; or

B. Specialist not possessing specialty board certificate:

- 1. Completed three years of formal Residency Training in Neurology acceptable to the American Board of Psychiatry and Neurology and at least 50 per cent of practice devoted to Neurology; or
- 2. Completed three years of formal Residency Training in Neurology acceptable to the American Board of Psychiatry and Neurology and recognized as specialist in Neurology by the local or State Medical Society where he practices; or
- 3. At least four years' experience in the practice of Neurology (which may include time spent in Neurological Residency Training) and at least 50 per cent of practice devoted to Neurology; or
- 4. At least four years' experience in the practice of Neurology (which may include time spent in Neurological Residency Training) and recognized as specialist in Neurology by the local or State Medical Society where he practices.

V. STANDARDS FOR DESIGNATION OF SPECIALISTS OTHER THAN IN PSYCHIATRY OR NEUROLOGY

- A. Certification by the appropriate specialty board;
- B. Specialist not possessing specialty board certificates;
 - 1. At least four years' experience in a given specialty (including recognized residency) and
 - 2. At least 50 per cent of practice devoted to a given specialty, and
 - 3. Recognized as Specialist by the Medical Association or Society in the State in which he practices, or
 - 4. Has been declared eligible to take all parts of the certifying examination of the Board concerned.

SECTION I
MEDICAL SERVICES

VISITS AND EXAMINATIONS — GENERAL

0005—Complete general routine physical examination including routine urinalysis (chemical)—this item may be authorized for first office visit or first home visit when applicable.....	\$10.00
0020—Examination to determine need for aid and attendance, in home.....	5.00
0025—Examination to determine need for aid and attendance, in office.....	4.00
0030—Examination to determine need of hospitalization, in home (day—8 A. M. to 7 P. M.).....	5.00
0035—Examination to determine need of hospitalization, in home (night—7 P. M. to 8 A. M.).....	7.00
0040—Examination to determine need of hospitaliza-	

tion, in office.....	4.00
0045—Home visit, (day—8 A. M. to 7 P. M.).....	5.00
0050—Home visit, (night—7 P. M. to 8 A. M.).....	7.00
0055—Hospital visit, (day—8 A. M. to 7 P. M.).....	4.00
0060—Hospital visit, (night—7 P. M. to 8 A. M.).....	7.00
0065—Mileage one way for day or night visit outside city limits (in addition to appropriate fee).....	.75
0070—Office visit	4.00

EXAMINATIONS BY SPECIALISTS

0075—Allergy survey, complete, including history, physical examination, relevant laboratory procedures (skin tests, smears of sputum and nasal secretions, vital capacity, etc.) and report.....	25.00
0090—Cardiac examination including electrocardiogram	15.00
0095—Dermatological	10.00
0100—Ear examination with audiogram and interpretation	10.00
0110—Ear examination, including caloric or Barany test with audiogram and report.....	15.00
0115—Electrocardiogram with interpretation.....	10.00
0125—Examination of ears, nose and throat.....	5.00
0130—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, as well as a report of abnormalities found	15.00
0135—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, together with a report of the visual field findings (the latter by chart if the field is abnormal).....	15.00
0140—Examination by internist to determine diagnosis	10.00
0145—Examination by neurologist to determine diagnosis	10.00
0150—Examination by psychiatrist to determine diagnosis	15.00
0155—Examination by physiatrist to determine diagnosis and/or to evaluate residual disability.....	7.50
0160—General surgical	10.00
0165—Genitourinary examination with cystoscopy.....	35.00
0170—Genitourinary examination without cystoscopy including prostatic smear and urinalysis.....	10.00
0175—Gynecological	10.00
0180—Orthopedic	10.00
0185—Physical examination of lungs.....	10.00

OUT-PATIENT TREATMENT BY SPECIALISTS

0200—Dermatological: first visit or home visit.....	7.00
0205—Dermatological: each subsequent office visit.....	5.00
0210—Ear, nose and throat: first visit or home visit.....	7.00
0215—Ear, nose and throat: each subsequent office visit	5.00
0220—Neurologic treatment	10.00
0225—Ophthalmological: first visit or home visit.....	10.00
0230—Ophthalmological: each subsequent office visit	5.00
0235—Psychiatric treatment, one half hour or less.....	7.50
0240—Psychiatric treatment, period longer than one half hour	15.00

0245—Other comparable specialties not listed above: First visit or home visit.....	10.00
0250—Other comparable specialties not listed above: Each subsequent office visit.....	5.00

PHYSICAL MEDICINE AND REHABILITATION

Note: As components of physical medicine and rehabilitation, occupational therapy and physical therapy treatment are administered by occupational and physical therapists on prescription of a physician (preferably a physiatrist). In instances where therapists are not available, treatment may be administered by a physician.

PHYSICAL MEDICINE AND REHABILITATION EXAMINATION

0300—PM&R, examination and evaluation, diagnostic, for prescription of physical therapy and/or occupational therapy	10.00
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MISCELLANEOUS MEDICAL TREATMENT AND SERVICES

Note: A physician who dispenses drugs or biologicals will consider this service included in his established visit fee when the drugs are routine nonexpensive items. When an expensive drug is required, it is suggested that the physician prescribe (it is understood that a physician may prescribe all drugs, expensive and nonexpensive) and the prescription be filled at a VA pharmacy or by a pharmacy participating in a State pharmaceutical plan.

ALLERGY AND DERMATOLOGY

0640—Skin tests—diagnostic only, intradermal or scratch, 40 extracts.....	15.00
0645—Skin tests—intradermal or scratch test.....	25

OTHER MEDICAL SERVICES

0695—Determination of basal metabolic rate.....	5.00
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RADIOLOGY

4025—Gastrointestinal, including barium meal and enema, x-ray and fluoroscopy with preliminary KUB film	35.00
---	-------

PATHOLOGY

5245—Blood smear for malaria.....	3.00
5270—Chemical examination of blood complete, including creatinin, dextrose, urea, nitrogen (or NPN) and uric acid.....	15.00
5290—Complement-fixation tests for syphilis.....	3.50
5365—Precipitation, microfloc for syphilis.....	2.50
5380—Red, white and differential blood counts including instrumental colorimetric hemoglobin estimation	5.00
5730—Spinal fluid Wassermann (complement-fixation)	3.50

SPUTUM

5815—Sputum examination for tubercle bacilli (plain smear)	2.00
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URINE

5955—Urinalysis, routine chemical and microscopic.....	2.00
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American Cancer Society Names New Executive

Dr. Harold S. Diehl, dean of the College of Medical Sciences, University of Minnesota, long active in committee work of the American Medical Association, is taking on an important new assignment with the American Cancer Society November 1.

At that time he will become senior vice president for research and medical affairs and deputy executive vice president of the society.

Cancer society President David A. Wood said "the appointment can be viewed as an important contribution to a 'speed-up' offensive against cancer," adding: "Dr. Diehl will serve as chief medical and scientific officer of the society. The position is concerned primarily with the responsibilities of planning and policy rather than with routine operating duties."

For the time being Dr. Diehl will take his new position with the society on a leave of absence from the university. This will enable him to return to the campus periodically to carry forward a number of current projects and to assist with the transition to a new administration for the College of Medical Sciences which will be organized as soon as possible.

AMA Plans School Health Conference This Fall

"A Decade of Progress in Fitness" will be the theme of the sixth National Conference on Physicians and Schools to be held October 30 to November 2, at the Moraine-on-the Lake Hotel, Highland Park, Illinois. Sponsored by the AMA's Bureau of Health Education, this year's program will emphasize a continuing interest in the health and all-around fitness of children and youth.

More than 60 nationally recognized consultants have been selected from medicine, education, and public health to lead the discussion groups. Topics to be considered include: the physician's role in youth fitness, community coordination, mental and emotional aspects of fitness, dramatizing basic fitness procedures, medical guidance in girls' recreation programs, special health problems in athletics, fitness of school personnel, optimum fitness for youth with special problems, accident prevention, and food factors in fitness.

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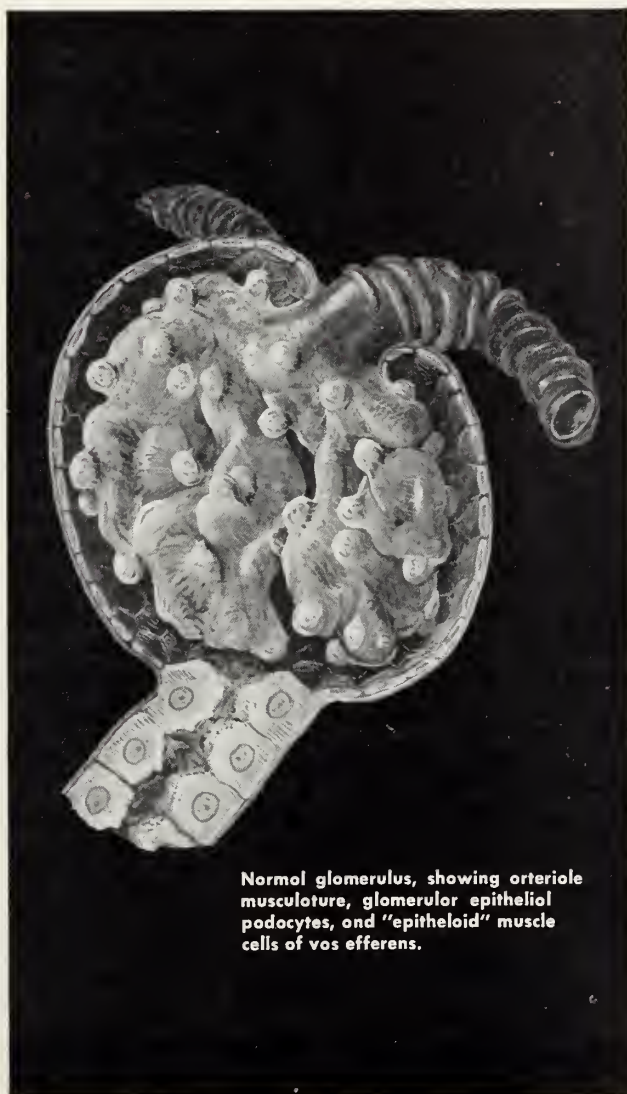
Laboratory studies demonstrate that Searle's new oral diuretic, Rolicton, causes positive diuresis with an essentially balanced excretion of water, sodium and chlorides.

Settel¹ studied the effect of Rolicton in forty-seven patients and found no serious side effects. Assali, who observed the action of Rolicton in five patients with severe toxemia of pregnancy, states² that side actions are essentially nonexistent. Side actions of such low incidence, together with its diuretic efficacy, suggest a high order of usefulness for Rolicton.

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1. Settel, E.: Rolicton[®] (Aminoisosmetradine), a New, Nonmercurial Diuretic, *Postgrad. Med.* 21:186 (Feb.) 1957.

2. Assali, N. S.: Personal communication, May 28, 1956.



Normal glomerulus, showing arteriole musculature, glomerular epithelial podocytes, and "epitheloid" muscle cells of vasa efferens.

SEARLE

If dangerous epidemics of Asian flu break out in the country this fall and winter, the medical profession will have its hands full. But the doctors won't be taken by surprise, nor will they lack specific information on proper treatment.

While the attacks in the U. S. were still sporadic and the death rate low—three fatalities in the first 11,000 reported cases—a number of major, nationwide efforts were under way to combat the disease in the months when influenza rates generally are the highest.

1. Acting in coordination with U. S. Public Health service, the American Medical Association was pressing forward with its campaign to insure that all physicians are informed of how to deal with the disease.

2. In line with recommendations of the AMA committee, a number of State medical societies by mid-August had laid out complete emergency plans, ready to be put in operation if needed.

3. U. S. Public Health Service epidemic intelligence experts were scanning the country for outbreaks that might be Asian influenza, and other PHS officers were investigating acute respiratory diseases. PHS also set up machinery to keep the medical and health professions informed on nationwide developments in the influenza picture.

4. Advising Surgeon General Burney was a special committee, which included representatives from AMA, American Academy of Pediatrics, American Academy of General Practitioners and the Association of State and Territorial Health Officers.

5. Manufacturers of the vaccine, by running their plants on two or three shifts and seven days a week, were hoping to have produced 60,000,000 cc. by February 1.

There was, of course, the possibility that with Congress in session through most of the summer a vast federal program would be set up, with the U. S. purchasing and allocating the vaccine. It was heartening to the medical profession that this possibility was pretty well eliminated in the early stages when

the Department of Health, Education, and Welfare announced the following as official policy:

"The Public Health Service, in cooperation with the medical profession, will stimulate and promote a nationwide voluntary program of vaccination against the prevalent strain of influenza. It will not, however, request federal funds for the purchase or administration of vaccine—except for its own legal beneficiaries. The State and Territorial health officers and the American Medical Association have jointly assured the Surgeon General that community resources, both public and private, will be mobilized to provide vaccinations for persons who are unable to pay for such protection."

This policy was reaffirmed later by the White House, when the President asked for half a million dollars to finance the additional work for Public Health Service. The White House statement said flatly that it did not plan to have the federal government buy vaccine.

The AMA's Board of Trustees selected as members of the special committee the same physicians who make up the Civil Defense Committee, with Dr. Harold C. Lueth as chairman. In addition to the work of this committee, special articles are being published in the *AMA Journal*, mass circulation media are being used to bring information on Asian influenza to the lay public and the AMA Council on Drugs is investigating and reporting to physicians on the use of antibiotics in treatment of the disease.

Col. Long Takes Charge of Preventive Medicine

New chief of preventive medicine division in Army Surgeon General's Office is Col. Arthur P. Long. His assistant, also newly appointed, is Col. Philip R. Beckjord. Both hold advanced degrees in public health, Col. Long from Harvard and Col. Beckjord from University of Minnesota and Johns Hopkins.

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Establish Registry of Pediatric Pathology

The chairman of the committee on pediatric pathology of the American Academy of Pediatrics has announced that under the auspices of the American Academy of Pediatrics, a special registry, devoted to pediatric pathology, is to be established as a component of the American Registry of Pathology of the Armed Forces Institute of Pathology. The advantages of a registry of pediatric pathology accrue from the special character of pathology as seen in children. The registry of pediatric pathology will limit its material only with respect to the age group involved. Adequate cataloguing, maintenance of records and availability of material are primary objectives in the procedure. A consultation service will be provided for all pathologists, similar to that offered by the other component registries. Leading authorities in pediatric pathology in this country and abroad will thus be on call for questions in their special fields of interest. The material will also be made available for teaching purposes and it is hoped that in the future, the registry may provide a position for training in pediatric pathology. The support of all pathologists and pediatricians, is said to be needed to insure the success of this new division. Inquiries concerning it should be addressed to the Registry of Pathology at the Armed Forces Institute of Pathology, at Walter Reed Medical Center, 6825 16th Street, N.W., Washington 25, D. C. All interested physicians are invited to visit the registry. The committee on pediatric pathology of the American Academy of Pediatrics consists of Drs. Sidney Farber, professor of pathology, Harvard Medical School, Boston, chairman; Edith L. Potter, associate professor of obstetrics and gynecology, University of Chicago, the School of Medicine, Chicago; Irving J. Wolman, associate professor of pediatrics, University of Pennsylvania School of Medicine, Philadelphia; William B. Kiesewetter, associate professor of surgery, University of Pittsburgh School of Medicine, Pittsburgh; George H. Fetterman, associate professor of pathology, University of Pittsburgh School of Medicine, Pittsburgh; Robert S. Cleland, Los Angeles; Major Daniel Stowens, MC, of the Armed Forces Institute of Pathology, is secretary of the committee.

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It Isn't Too Costly

U. S. News & World Report has published a lengthy article on the question of whether doctors' fees and other medical expenses are too high or not high enough. This account is largely factual in nature—and some of the facts deserve widespread understanding.

Medical costs, like all other costs, have risen. Even so, over a considerable period of time—1936 to the present—average charges by doctors have risen substantially less than the cost of living as a whole. And the typical charge made by a doctor for a home visit is little if any more than that of a TV repairman or other mechanic.

Hospital charges have undergone what the magazine calls "a spectacular rise." Yet a profit-making hospital is a rare institution, and most hospitals look to gifts and revenue sources other than patients' payments to balance the books.

What has happened is that, in addition to the general living and operating cost jumps that have hit medicine along with everything else, we now demand and get much more medical service than we used to. There are all manner of valuable drugs and other aids to recovery that didn't even exist a comparatively few years back. The services of specialists are in ever-greater use. And people go to hospitals where they used to be served at home. For instance, *U. S. News* says that in 1956, all but a small proportion of babies were born in hospitals—where as late as 1935, this was true of only 37 per cent of infants.

The magazine estimates that the average family pays \$278 a year for medical care—a figure that includes doctors, dentists, optometrists, hospitalization, drugs and prescriptions, and health insurance. Most people will agree that we get a great deal in return for that sum. And there is every indication that, by and large, the costs are as moderate as the conditions of the time permit.

Veterans Administration is increasing fees to physicians under the hometown care program, with the new schedules varying by States and areas. During this fiscal year VA will pay out \$8 million under this program.

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John R. Eddy, M.D. announces the opening of an office for the practice of internal medicine at 153 Main Street, Manchester.

George B. M. Lornie, M.D. announces the opening of an office for the general practice of medicine at 610 White Plains Road, Trumbull.

Jorge L. Paras, M.D. announces the opening of an office for the practice of psychiatry at 121 Main Street, Middletown.

Edward Bruce Swain, M.D. announces the opening of an office for the practice of psychiatry at 7 South Main Street, West Hartford.

Robert J. Williamson, M.D. announces the opening of an office for the practice of general surgery in association with Dr. Philip Brezina, at 105 Woodland Street, Bristol.

GASTROENTEROLOGICAL CONVENTION

The 22nd Annual Convention of the American College of Gastroenterology will be held at The Somerset in Boston, Massachusetts, on October 21, 22, 23.

In addition to the many individual papers to be presented, there will be panel discussions on Chronic Ulcerative Colitis, Diseases of the Esophagus, Peptic Ulcer and the Management of Massive Gastrointestinal Hemorrhage in Patients with Liver Disease. There will again be scientific as well as commercial exhibits and the sessions will be open to all physicians without charge.

On October 24, 25 and 26, immediately following the Convention, Dr. Owen H. Wangenstein of Minneapolis, Minnesota and Dr. I. Snapper of Brooklyn, N. Y., will again be the moderators of the Annual Course in Postgraduate Gastroenterology. The sessions will be held at The Somerset and in the Joslin auditorium of the New England Deaconess Hospital. Attendance at the Course will be limited to those who have registered in advance.

This year marks the Twenty-Fifth Anniversary Year of the College and silver certificates are to be presented to those who have been affiliated with the organization since its inception.

Honorary Fellowships are to be presented to Dr. Chester S. Keefer, Boston, Massachusetts, Dr. William W. Frye, New Orleans, Louisiana, Dr. Stafford L. Warren and Dr. Rafe C. Chaffin, both of Los Angeles, California.

Copies of the program and further information concerning the Postgraduate Course may be obtained by writing to: American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

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AROUND THE STATE

Hartford County

James C. Hart, director of the Bureau of Preventable Diseases of the State Department of Health stated on August 23 that six of the ten adult cases of polio recorded in the State this year had received no immunization and that the other four had not completed the full series of three injections. "Public apathy especially among adults in obtaining polio immunization shots, has created a serious health problem both in Connecticut, and throughout the country," Dr. Hart said. Less than two-thirds of the Legislature's \$425,000 appropriation for polio vaccine had been spent up to that time. If public demand for vaccine did not increase substantially Dr. Hart estimated that further stockpiling vaccine would be inadvisable owing to the fact that the effective life of the vaccine is only six months.

Two hundred persons attended a testimonial dinner on August 25 in honor of Dr. and Mrs. Raoul J. Benoit, honorary senior gynecologist and obstetrician at the New Britain General Hospital at St. Jean Baptist Hall in New Britain. Dr. and Mrs. Benoit are leaving New Britain to live in Bel-Air Florida. Among those present were Mayor Joseph F. Morelli and the Rev. Raymond J. Marceau of Cromwell.

Middlesex County

Dr. Clair B. Crampton of Middletown has been elected president of the Consulting and Visiting Staff Organization at Connecticut State Hospital. Dr. Harry S. Whiting, assistant superintendent, reported recently. The list of consultants was recently approved by the board of trustees.

Other officers of the organization which supervises the work of the consultants in cooperation with the hospital staff include: Vice president, Dr. Harry S. Frank; Secretary, Dr. Mark Thummin; and executive committee, the officers and Dr. Stanley J. Alexander and Dr. Louis O. LaBella of the consulting and visiting staff; and Dr. Marshall E. Smith, Jr. and Dr. A. Benjamin Rafkind of the hospital staff.

The members of the consulting and visiting staff approved by the trustees are as follows, all from Middletown except as noted: surgery, Dr. Donald C. Arnault, Dr. Harry S. Frank, Dr. Louis O. LaBella and Dr. Vincent J. Vinci; internal medicine, Dr. Stanley J. Alexander, Dr. Harold E. Speight and Dr. F. Erwin Tracy; anesthesiology, Dr. William F. Bauer, Jr., Dr. Richard F. Grant, Dr. Joseph Magnano, Dr. R. B. Pennington and Dr. Ralph M. Tovell of Hartford; ophthalmology, Dr. Carl C. Chase and Dr. William M. Joyce; gynecology and obstetrics, Dr. Crampton, Dr. G. Mansfield Craig and Dr. A. W. Thomson; neurosurgery, Dr. Rembrandt H. Dunsmore, Dr. Francis G. Reilly, Dr. William B. Scoville and Dr. Benjamin B. Whitcomb, all of Hartford.

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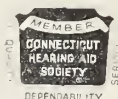


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ALLAN DUBIN, 83 Fairfield Avenue
CHARLES H. HILL, 945 Main Street
STEPHEN OGILVY, 130 John Street

Diseases of the chest, Dr. Cole B. Gibson, Meriden; orthopedic surgery, Dr. James R. Glessner, Dr. Walter N. Nelson of Cromwell and Dr. Alfred N. Sweet; thoracic surgery, Dr. R. Leonard Kemler, Hartford; urology, Dr. Harry C. Knight and Dr. Floyd D. Roos; oral surgery, Dr. Stephen M. Koch, Meriden; cardiology, Dr. Herbert Levine; peripheral vascular diseases, Dr. Robert I. Lowenberg, New Haven; neuropsychiatry, Dr. Philip J. Moorad of New Britain, and Dr. Charles Russman, former assistant superintendent; dermatology, Dr. Philip Schwartz; and ophthalmology and otolaryngology, Dr. Thumim.

Several outstanding psychologists from universities in the State have been named to the advisory and consulting groups for the Psychological Laboratories at Connecticut State Hospital.

Named to the Psychological Advisory Committee were Maria S. Rickers-Ovsiankina, PH.D., professor of psychology, University of Connecticut; Seymour B. Sarason, PH.D., professor of psychology, Yale University; Robert H. Knapp, PH.D., Wesleyan University; and Max Levin, PH.D., executive secretary, Foundations' Fund for Research in Psychiatry, New Haven.

Dr. Whiting reported that the trustees also approved the appointment of consultants in psychology as follows: Dr. Knapp and David McAllester, PH.D., Wesleyan University; and from Yale University, Irving N. Baer, M.D., Irvin L. Child, PH.D.; Irving L. Janis, PH.D.; Ethelyn H. Klatskin, PH.D.; Roy Schafer, PH.D.; and Dr. Sarason.

Also named to the consulting staff were George F. Mahl, PH.D., associate professor of psychiatry (psychology), Yale University; Walter W. Igersheimer, M.D., assistant clinical professor of psychiatry, Yale; and David Shapiro, PH.D., of the Austin Riggs Foundation, Stockbridge, Massachusetts.

New Haven County

The City of New Haven has appointed a special Mayor's advisory committee on the problem of the inoculation of residents against Asiatic influenza. Chairman of the committee is Public Health Director, Dr. Clement F. Batelli. Serving with him are Dr. Gunar Bohan, director of Medical Services for the city; Albert W. Snoke, director of Grace-New Haven Hospital; Dr. Daniel Levy, vice president of the New Haven Medical Association, and Dr. Harvey Kaetz, Dr. Nicholas LaFemina, Dr. Joseph Mignone and Dr. Walter I. Russell.

Dr. John McLean Morris, president of the New Haven Cancer Society has announced the appointment of Gioacchino S. Parrella, chief of surgery at the Milford Hospital, as the new medical advisory committee chairman for the cancer society. Dr. Parrella succeeds Dr. Theodore S. Evans who has served as chairman of the medical committee for several years. He has appointed to assist him Dr. Wayne P. Whitcomb of the Hospital of St. Raphael; Dr. Charles M. D'Alessio of Griffin Hospital, Derby; Dr. Carter Stilson, Dr. Donald P. Shedd of the Yale Medical School and Dr. Clement F. Batelli, health director for the city.

A reception was held at St. Mary's Hospital in Waterbury for the new house staff of physicians who began service in July. Among the guests were twenty-five interns and residents specializing in surgery, internal medicine, obstetrics and gynecology, orthopedics, radiology and pathology. The reception was the first of its kind at St. Mary's and was designed to afford an opportunity to the house staff members and their wives to meet the executive staff of the hospital. Representatives were present from the hospital's administrative departments, including the board of directors, chief of staff, directors of the adjunct services departments, officers of the medical staff, officials of the School of Nursing, pharmacists, members of the medical records department, operating room staff and business office. Hostesses at the coffee table were Mrs. Marcus E. Cox, wife of the hospital pathologist; Mrs. Kenneth R. Kaess, wife of the hospital radiologist and Mrs. Robert L. Pollard, wife of a member of the committee on graduate training and chief of pediatrics.

Tolland County

Joseph J. Kristan of Rockville has been appointed town health officer by the Board of Selectmen. The new appointment was made following the resignation of Roy C. Ferguson last week. Dr. Ferguson was town health officer for twenty years. Dr. Kristan has been practicing in Rockville since July 1955. A graduate of Johns Hopkins Medical School in 1945, he served in the Army Medical Corps during World War II and in the Army Air Force during the Korean War. He came to Rockville from the Newington Veterans Administration Hospital. He is a member of the Aero-Medical Association and is presently in the Air Force Reserves. He was recently placed in charge of the Civil Defense emergency hospital unit stored in Northeast School.



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NEW BOOKS IN REVIEW

PRACTITIONERS' CONFERENCES. Volume 6. Edited by Claude E. Forkner, M.D., F.A.C.P. New York: Appleton-Century-Crofts, 1957. 378 pp. \$6.75.

Reviewed by ARTHUR D. WOLF

As a method of presenting a variety of medical knowledge in an interesting, readable, and informative manner, the publication of a book such as "Practitioners' Conferences" proves an admirable way to meet this challenge. Volume 6 is apparently no exception to the previous works in this series. It represents a collection of 15 different subjects, chosen to represent in both content and resources utilized the many disciplines inherent in the variegated practice of medicine today.

Each topic is in itself a conference held at the New York Hospital-Cornell Medical Center, to which all physicians in the area are invited. To read one of these conferences is to feel almost as if you were there. For as well as being filled with fact, they are imbued as well with the spark of personality. Each conference has at least four resource members on its panel. These are men drawn from basic sciences as well as clinical medicine, men that are frequently well known figures in their field, and men that don't hesitate to differ from one another when their convictions so dictate. (Some of the most enlightening conferences are those wherein promulgators of fact become protagonists of opinion, and important differences are freely aired.) But the strongest personality of all is that of Dr. Claude Forkner, who in acting as moderator of almost all the conferences pursues a wise course of impartiality, of holding the material presented strictly to the point, of seeking to illuminate the many facets of a subject without ignoring the essence of its core. He does so always with humor and humility, with far-reaching wisdom and realistic practicality. His method is further abetted by the inclusion in every conference of at least two case presentations, and the inclusion at the end of each conference of a carefully prepared, point-by-point summary.

This volume, by including gout and encephalitis, literally covers the human body from the tip of the toe to the top of the head. In so doing there are also conferences on trichinosis, endometriosis, and dermatophytosis; on cancers of the thyroid, the prostate, and the esophagus as well as tumors of the lung and of bone; on portal hypertension, poison ivy, contact dermatitis, and early detection of heart disease; and on more ethereal subjects such as consultations with anesthesiologists, and whether patients should be told the truth about serious illness. Frequently the speakers are extremely candid, whether about their own or someone else's viewpoint. Often they are most practical. Always they are informative.

The style of this book makes it easy to read and follow, for it is printed as if a script for a drama. Its errors, such as "transferred" for transfused, "upper right" for upright, and "irridation" for irradiation; and the switch of captions for two x-ray pictures are so minor as to be negligible.

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The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XXI

NOVEMBER, 1957

No. 11

THIRTY-SECOND CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

HOTEL STATLER, HARTFORD

December 11, 12, 1957

GENERAL INFORMATION

REGISTRATION FEE

The registration fee of \$5 provides for admission to all sessions of the Congress.

Hospital residents, interns, and medical students will be admitted without charge, if a statement of their position signed by an official of the hospital or medical school is presented at the registration desk.

MEETING PLACE

All of the sessions will be held in the Ballroom and the Boston, Buffalo, New York, and Washington Rooms of the Hotel Statler.

TELEPHONE

Telephone messages will be received at Hartford, CHapel 9-5611.

LUNCHEON

Luncheons will be available in the regular dining rooms.

PARKING

There are public parking areas near the hotel and metered curb parking.

HOTEL ACCOMMODATIONS

Persons who wish to remain over night should make reservations as soon as possible.

NOTE: Twelve hours of Study Course Credit (Category I) will be given for attendance at this Congress by the American Academy of General Practice.

PROGRAM
THIRTY-SECOND CONNECTICUT CLINICAL CONGRESS
HOTEL STATLER, HARTFORD
WEDNESDAY, DECEMBER 11, 1957

9:15 REGISTRATION ON MEZZANINE

BALLROOM

William J. Lahey, *Hartford, presiding*

9:45 CARDIAC FLUOROSCOPY

John B. Schwedel, *New York City; Attending Physician, Medical Service, Montefiore Hospital; Assistant Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons*

10:30 PULMONARY EDEMA

James V. Warren, *Durham, North Carolina; Professor of Medicine, Duke University School of Medicine; Physician, Duke Hospital*

BOSTON ROOM

Louis F. Middlebrook, *Hartford, presiding*

9:45 ALDOSTERONISM

Frederic C. Bartter, *Bethesda, Maryland; Chief, Section of Clinical Endocrinology, Clinic of General Medicine and Experimental Therapeutics, National Heart Institute*

10:30 DISORDERS OF MENSTRUAL FUNCTION

Howard Ulfelder, *Boston, Massachusetts; Clinical Professor of Gynecology, Harvard Medical School; Chief of Gynecology Service, Massachusetts General Hospital*

11:15 INTERMISSION TO VISIT TECHNICAL EXHIBITS

BALLROOM

John C. Leonard, *Hartford, presiding*

11:30 CLINICOPATHOLOGICAL CONFERENCE

Stanley L. Robbins, *Boston, Massachusetts; Professor of Pathology, Boston University Medical School; Associate Director, Mallory Institute of Pathology*

Discussants: N. William Wawro, *Hartford*

Ettore F. Carniglia, *Hartford*

12:30 LUNCHEON

WEDNESDAY, DECEMBER 11, 1957

BALLROOM

Stevens J. Martin, *Hartford, presiding*

2:00 PANEL ON LUNG FAILURE

Robert E. Forster, *Philadelphia, Pennsylvania; Associate Professor of Physiology, Graduate School of Medicine, University of Pennsylvania*

Edward A. Gaensler, *Boston, Massachusetts; Associate in Surgery, Harvard Medical School, Associate Visiting Surgeon (Thoracic), Boston City Hospital*

Discussant: Max G. Carter, *New Haven*

3:00 INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:15 MEDICAL PROBLEMS IN ADOLESCENCE

J. Roswell Gallagher, *Boston, Massachusetts; Chief, the Adolescent Unit, Children's Hospital, Boston; Lecturer on Pediatrics, Harvard Medical School*

4:15 ADJOURNMENT

BOSTON ROOM

4:30 SEMI-ANNUAL MEETING, HOUSE OF DELEGATES, CONNECTICUT STATE MEDICAL SOCIETY

Cole B. Gibson, *Meriden, Speaker of the House, presiding*

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9. Merck Sharp & Dohme, Philadelphia, Pennsylvania
10. Connecticut Medical Service, New Haven, Connecticut

THURSDAY, DECEMBER 12, 1957

9:15 REGISTRATION ON MEZZANINE

BALLROOM

Malcolm M. Ellison, *New London, presiding*

9:45 METABOLIC PROBLEMS OF POSTOPERATIVE PATIENT

Henry T. Randall, *New York City; Clinical Director and Chairman, Department of Surgery, Memorial Center for Cancer and Allied Diseases; Professor of Surgery, Cornell University Medical College*

10:30 THE CHOICE OF TREATMENT FOR BREAST CARCINOMA (Radical versus Simple Mastectomy and the Place of Radiation)

Cushman D. Haagensen, *New York City; Director of Surgery, Francis Delafield Hospital; Professor of Clinical Surgery, Columbia College of Physicians and Surgeons*

BOSTON ROOM

Howard Levine, *New Britain, presiding*

9:45 DIARRHEA IN CHILDREN

Robert E. Cooke, *Baltimore, Maryland; Professor of Pediatrics, Johns Hopkins University School of Medicine; Pediatrician-in-Chief, Johns Hopkins Hospital*

10:30 MANAGEMENT OF RESTLESSNESS AND SLEEPLESSNESS

John C. Krantz, Jr., *Baltimore, Maryland; Professor of Pharmacology and Head of Department of Pharmacology, University of Maryland School of Medicine*

11:15 INTERMISSION TO VISIT TECHNICAL EXHIBITS

BALLROOM

Benjamin V. White, *Hartford, presiding*

11:30 CLINICOPATHOLOGICAL CONFERENCE

Edward A. Gall, *Cincinnati, Ohio; Professor of Pathology, University of Cincinnati College of Medicine; Director of Laboratories, Cincinnati General Hospital*Discussants: Max Taffel, *New Haven*Samuel D. Kushlan, *New Haven*

12:30 LUNCHEON

THURSDAY, DECEMBER 12, 1957

BALLROOM

Gray Carter, *Greenwich*, presiding

2:00 PANEL ON MODERN TRENDS IN TREATMENT OF PANCREATIC DISEASE

Alexander Brunschwig, *New York City*; Professor of Clinical Surgery, Cornell University Medical College; Attending Surgeon, Chief of Service, Memorial Hospital for Cancer and Allied Diseases

David A. Dreiling, *New York City*; Assistant Professor of Clinical Surgery, Albert Einstein College; Assistant Attending Surgeon, Mt. Sinai Hospital

Discussant: Robert E. Cooke, *Baltimore, Maryland*

3:00 INTERMISSION TO VISIT TECHNICAL EXHIBITS

BALLROOM

Program Arranged by Connecticut Chapter—American Academy of General Practice

3:15 SYMPOSIUM—THE GENERAL PRACTITIONER, HIS PLACE IN THE HOSPITAL AND THE COMMUNITY

Moderator: Richard B. Elgosin, *Hamden*

Panel: Richard P. Bellaire, *Saranac Lake, New York*; Member of the Hospital Commission, American Academy of General Practice

Mark A. Hayes, *New Haven*; Associate Professor of Surgery, Yale University School of Medicine

John C. Leonard, *Hartford*; Director of Medical Education, Hartford Hospital

Mr. Charles V. Wynne, *Waterbury*; Administrator, Waterbury Hospital

4:30 Adjournment

THE CLINICAL CONGRESS COMMITTEE IS COUNTING ON YOUR ATTENDANCE AT LEAST AT SOME OF THE SESSIONS, IF NOT AT ALL. THIS OPPORTUNITY FOR POSTGRADUATE STUDY IS VERY TIMELY AND SHOULD NOT BE DISREGARDED BY ANY PHYSICIAN PRACTISING MEDICINE IN CONNECTICUT

PSYCHOSOMATIC REACTIONS ASSOCIATED WITH PREGNANCY

EDWARD C. MANN, M.D., *New York, N. Y.*

I PROPOSE to discuss a component part of comprehensive maternity care: namely, the recognition, prevention, and management of some of the emotional complications of pregnancy.

As busy practitioners skilled in the art of medical and operative obstetrics, we tend to regard pregnancy in a syndromic light. That is to say, we are sensitized and attuned to the trains of symptoms and eventualities which may occur in pregnancy and are full of pride of, if not complacent in, our manipulative abilities to cope with most of these gestational conditions, be they contingent upon an ordered or disordered physiology. In this process of fixing upon the conditional aspects of pregnancy we often lose sight of the experiential aspects of pregnancy. This is a significant oversight, for to the pregnant woman pregnancy is no less an experience than a condition.

Indeed, pregnancy is the basic experience by way of which woman brings herself to her own creativity. As such it is an experience in self fulfillment. Recognizing this, we tend, culturally and professionally, to regard the expectant mother as an acceptant mother. In so doing we are inclined to view fertility as the sole precondition for motherhood.

PSYCHOGENIC INFERTILITY

Such a literalistic approach is perhaps best exemplified in our dealings with infertility patients. In such patients we typically search for a disordered ovarian, uterine, tubal, cervical, or seminal factor to explain their sterility and only after failing in this, if then, look for an emotional factor. In the process we, not infrequently, waste our time and the patient's money. In this connection we recently were seeing a patient in our sterility clinic who over a period of many months had, from the standpoint of her reproductive physiology, been thoroughly investigated. After a host of procedures, which included endometrial biopsy, tubal insufflation, hysterosalpingography, and semen analyses, the

The Author. *Commonwealth Fellow in Obstetrics and Gynecology, Department of Obstetrics and Gynecology, Cornell University Medical College, New York Lying-In Hospital; formerly Instructor in Psychiatry, Johns Hopkins University*

SUMMARY

Pregnancy is a condition as well as an experience and fertility is not the sole precondition for motherhood. Women examined in fertility clinics often arrive there because of some extraneous influence when in reality they do not want to become pregnant. For this reason they present emotional defenses against pregnancy.

Habitual abortion may be the result of emotional conflicts. These women, like the infertile patients, may accomplish one or more successful pregnancies with proper psychiatric treatment.

Other women give evidence of protesting against pregnancy by developing hyperemesis gravidarum of such sufficient severity to require hospitalization. Supportive psychotherapy is of value here but only when there is a good doctor-patient relationship. The physician must get to know his patient if his treatment of abnormal emotional reactions is to be successful. There is no room in this field for hurried obstetrical care.

patient was eventually seen by one of the clinic doctors who, for the first time, questioned her as to her personal feelings regarding her infertility. To his dismay, she quite forthrightly stated that she was coming to the clinic only at the insistence of her mother-in-law, that she was afraid of becoming pregnant, and, what is more, that throughout the period of her sterility work-up she had been using a diaphragm.

While such an example is gross and representative of voluntary rather than involuntary sterility it

Presented on program on Recent Changes in Medicine and Infant Care at Berlin, Connecticut, April 10, 1957

illustrates a kind of outwardly conforming, inwardly nonconforming behavior frequently seen in the more subtle forms of psychogenic infertility. Usually, as in the case just cited, the conforming aspects of the patient's behavior obscure the more devious, nonconforming aspects of her behavior so that we tend to be mindful of her "doings" and unmindful of her "undoings." As a result we either ignore or rationalize away clues and hints which may be the very key to the patient's infertility. These clues and hints of which I speak are manifestations of the patient's emotional defenses against pregnancy. These may take many forms, may occur at different levels of awareness, and may entail the use of psychophysiologic mechanisms.

For purposes of illustration I can think of no better case than a patient whom I am currently seeing.

Several months ago in the course of my rotation through the sterility clinic I was called upon to inseminate artificially one of our infertility patients with her husband's specimen. I had never seen the patient before, but in looking over her chart I noted that both she and her husband had been completely worked up and both had been found to be free of pathology which might explain their barren marriage. In consequence, it had been decided that a course of inseminations be tried. After I introduced myself to the patient in the treatment room she quite pleasantly announced that this was her first experience with artificial insemination but that she "just knew" that it would work. She then facetiously toasted "the next President of the United States" with her husband's specimen before handing it to me and, in the process, dropped the specimen on the floor, where the container broke. I attributed this to accident, reassured her, and suggested that she return in two days with another specimen. Upon her return all went well until after I had placed the cervical cup containing the specimen over her cervix, at which point the patient became nauseated and began vomiting. My suspicions by then were definitely aroused, but thinking that perhaps my manipulation of the cervix might have triggered off the nausea reflexively I told the patient to return again in two days with another specimen. On this third occasion I secreted the specimen in the waste basket and then went through the usual motions but actually did nothing more than insert a speculum into the vagina. When she again became nauseated and began to vomit I began to think in terms of hyperemesis gravidarum and decided that a talk with this patient was definitely in order.

I then sat down with the patient, confronted her with my impressions, and indicated that at least a part of herself seemed to be rebelling against the prospect of pregnancy. Although somewhat evasive and defensive at the outset of our discussions, she soon divulged the conflictual order of her feelings regarding pregnancy in such a way as to render her treatment room antics quite meaningful. Briefly, the patient's first husband, by whom she had had one child, had been killed in the Korean war. Two years after his death

she had married her present husband, whom she described as a thoughtful and considerate person save for his abiding inability to accept her child as his own. Prior to her marriage her present husband had indicated by words and action that he would have no difficulty in accepting the child as his own; however, during five years of marriage he had been unable to relate closely or warmly to the child and instead had become increasingly resentful of the child's presence, recently suggesting that the child go to live with the patient's mother. Moreover, he had in recent months become somewhat disparaging of the patient in connection with her five year history of infertility and on several occasions had intimated that unless she produced a child of their own their marriage would founder. Such intimidations on the part of the husband had produced both fear and resentment in the patient. Her desire to please and appease him had brought her to the sterility clinic, and yet her resentment over the treatment accorded her and her child had brought her to an unwitting, inner rebellion which had resulted in a type of psychophysiologic contraception.

Treatment consisted in working with both the patient and her husband. Several meetings with the husband, who actually was only dimly aware of his role in his wife's infertility, were productive of some major changes in his behavior toward both his wife and his stepchild, and the patient is now pregnant.

HABITUAL ABORTION

Just as some women, by virtue of conflictual emotional issues, are unable to bring themselves to the experience of pregnancy, there are others who, though able to bring themselves to the experience, are unable to complete it. Such patients, who have come to be called habitual aborters, are, from the standpoint of their management, uniquely challenging. Being successively unsuccessful in their gestational experiences they incline progressively to associate childbirth with childlessness and to equate pregnancy with unexpectant rather than expectant motherhood. Unlike the average woman, who miscarries on the basis of accidental causation which is nonrecurrent, the habitual aborter is subject to abortive sequences which are not self limiting. Indeed, the redeeming quality of randomness does not obtain in the habitual aborter, who aborts from a recurrent rather than a nonrecurrent cause and who, therefore, is a tandem rather than a random aborter. Accordingly, after a sequence of three successive spontaneous abortions the chances of losing the next pregnancy progress precipitously from statistical probability to almost statistical certainty so that the woman who has aborted repetitively on four occasions has only six chances out of 100 of carrying her next pregnancy to term.

Our experience at the New York Lying-In Hospital leads us to believe that the recurrent causal

factor giving rise to habitual abortion is emotionally determined. While we are still in the process of validating this belief, we have in the past two and one half years psychiatrically evaluated and followed over one hundred abortion-prone women who have had at least three consecutive spontaneous abortions. Of this number, 61 have become pregnant. Of these, 16 are still in various stages of pregnancy, 9 have miscarried, and 36 have delivered normal living infants. Considering only those patients in the study group who by virtue of delivery or abortion have responded successfully or unsuccessfully to our psychophysiologic approach, we have a total of 45 patients. While from a statistical standpoint this number is small, comparison of outcome of pregnancy before and after treatment merits mention. This group, among whom were 10 secondary aborters and 35 primary aborters, had, prior to treatment, a total of 194 pregnancies, 181 of which ended in miscarriages and 13 of which ended in viable births. Expressed comparatively, 93.4 per cent of all pregnancies before treatment ended in abortion; with treatment, 20 per cent ended in abortion.

Of more immediate significance than our statistical results is the striking similarity in personality makeup of the habitual aborters. These women have been remarkably alike in several emotional areas which seem to have determining importance in predisposing them to characteristic action and reaction patterns which, in turn, seem to underlie and give meaning to their abortive diathesis. Suffice it here to mention one of our most consistent findings. This has to do with the rather unusual type of relationship existent between the patient and her mother and father during her formative and puberal years. Almost invariably there is a history of paternal absence or inadequacy which has served to compromise the patient in her psychosexual maturation.

Perhaps the best way to highlight this is by way of illustrative case material.

Mrs. J. R., a 31 year old, primary, habitual aborter, was first seen approximately two years ago with a presenting complaint of her inability to carry a pregnancy to term. During her twelve years of marriage she had become pregnant on nine occasions, and each of these pregnancies had ended in spontaneous abortion at periods of gestation which ranged from three to five months. Gynecologic work-up, which included a hysterocervicogram, was entirely negative.

The patient was an extremely attractive individual who tended to ascribe her past abortive difficulties to a vague sense of unhappiness with her husband. History revealed

the patient to have been an only child, born of well-to-do parents. Her mother, a former actress, was said to have been an extremely beautiful woman who, while close and warm to the patient, was somewhat aloof and cold toward the patient's father, blaming him and their marriage for having cut short her promising career on the stage. He, in turn, idolized the patient's mother, indulging her every whim to the extent of allowing her to consort openly with one of her former suitors. In time this former suitor became a more or less permanent house guest so that by the time the patient was eight years old the "guest" was living with the patient's mother by day and even taking his meals with the entire family. The patient recalled this period of her life as having been an occasion for terribly mixed feelings. She loved and was loved by her mother, but she deplored her mother's adulterous behavior and the contempt in which her mother held her father. At the same time she loved and was loved by her father, but she agonized over his weaknesses. In this latter connection, throughout her late childhood and puberal years she prayed nightly to the Lord that He give her father sufficient strength to cast out the paramour from their lives.

When the patient was eighteen she met her husband who, like her father, was an attorney. Following their marriage the patient took an intense dislike to her husband's older brother, who was her husband's senior law partner and who in his aggressiveness reminded the patient of her mother's paramour. Very early in their marriage the patient began to chafe at her husband's subordinate position in the firm and began to magnify the older brother's cavalier treatment of her husband. Soon the patient was pleading with her husband to leave the firm; however, the husband, perhaps realistically, refused on the grounds that he was making good money and had a secure and promising future with his brother's firm. The patient, thereafter, gradually began to regard her husband as a disillusioning second edition of her passive father, and in this context the abortion habit developed.

As stated, the patient was seen for the first time several months after her ninth consecutive miscarriage. By then she was quite dissatisfied with her marital plight and, like her mother before her, had recently acquired a lover. When questioned as to the whys and wherefores of this clandestine relationship she stated quite matter of factly that, feeling as she did toward her husband, she would never be able to have a baby by him and that perhaps she could carry to term a pregnancy by someone else.

She was told that this was a destructive way of handling her difficulties, which seemed to have less to do with defectiveness on the part of her husband than with her early life experiences. She was advised to enter into psychotherapy in an effort to find a more constructive solution to her problem.

She asked for a few weeks to think it over, during which time her husband was seen on several occasions. He was found to be a likeable individual who, save for being somewhat passive, was fairly well rounded.

Several weeks later we received a telephone call from the husband thanking us for our efforts but stating that our services would no longer be required. When asked why, he stated that on the previous evening he had returned

home and had found his wife in the arms of a lover. In his anger he had badly beaten the lover and thrown him out into the street. He had then packed his bags, left home, and was now filing for divorce.

The next day the patient called, asking to be seen. She was almost psychotically depressed and completely uncomprehending of her husband's decision to divorce her. The patient talked quite seriously of suicide, and psychiatric hospitalization was considered. Instead, however, the husband was called, and the entire situation was explained to him. That is, the patient's behavior was explained to him in terms of her early life experiences. Having identified with her mother and having shared her mother's contempt for her father's passivity she had, in a neurotic fashion, attempted to live her life in imitative terms of her mother down to marrying a man in the defective likeness of her father. In the process she had distortedly reconstructed her marital life along the lines of her childhood. Believing her husband to be a carbon copy of her father, and therefore passive and ineffectual, she had in the recent escapade with the paramour set about, like her mother before her, to prove this belief. The husband, whose response to the paramour was utterly unlike her father's, had shattered this neurotic belief and in so doing had helped the patient overcome this perceptive disability which seemed to explain both her recurrent abortions and her more recent sexual acting out.

Although hurt and angry, the husband reluctantly accepted our explanation and agreed to defer divorce proceedings. They remained separated for a few months, at the end of which time a trial reconciliation was agreed upon.

He subsequently reported a great difference in his wife's attitude toward himself and their marriage and shortly thereafter agreed to another try at pregnancy.

The patient as a result of this corrective emotional experience could now see her husband in his own image rather than the reflected image of father and, in consequence, had no difficulty whatever with her tenth pregnancy, which three months ago ended in a full term, spontaneous delivery of an eight pound boy.

HYPEREMESIS GRAVIDARUM

Just as some women, on the basis of psychogenic sterility, cannot bring themselves to the experience of their own creativity, and others, on the basis of emotionally determined habitual abortion, can bring themselves to the experience but not complete it, there are others who having been passively brought to the experience must deviously protest. Perhaps the best psychosomatic example of the membership comprising this group is the hyperemesis patient. I speak now not of the physiological vomiter of early pregnancy but of the vomiter whose symptoms are overdetermined and who requires hospitalization. Often these patients are self martyring and feel that their husbands, to quote Sherwood Anderson, are keeping them "knocked up and barefooted." While the time-honored treatment of needles, solitude, and

darkness usually works by reducing the secondary gains of hospitalization, the most humane and certainly the best therapy is preventive in nature. These patients are extremely suggestible and respond very well to supportive psychotherapy, but only in the presence of a good doctor-patient relationship. If, failing this, hospitalization becomes necessary, every effort should be made to explore with the patient the emotional factor giving rise to her hyperemesis. In some hospitals hypnosis is used, and, according to most reports, this form of treatment is eminently successful.

Occasionally, there are curious twists to hyperemesis gravidarum which in one of our cases had a tragic ending.

The patient in point was a primagravida whom I had occasion to see on her first admission to the hospital for hyperemesis. I was summoned to the floor by the nurse immediately after the patient's admission primarily to handle the husband, who was wringing his hands and shouting at the nurses to do something for his wife, who, as he put it, was in dire need of medication and intravenous fluids. I examined his wife, started an intravenous medication, and assured the husband that his wife was in no danger. He gradually regained his composure and apologized for his behaviour, explaining it on the basis of his morbid fear of pregnancy. In this connection he stated that his mother had died giving birth to him and that, in consequence, he had an almost phobic fear of his wife dying in the course of this pregnancy. I reassured him to the contrary and then went in to talk to his wife.

She was unlike the run-of-the-mill hyperemesis patient in personality make-up, and in talking to her it became apparent that her hyperemesis was less a symptom for her than a symptom for her husband. In this connection she stated that throughout her pregnancy her husband had called home from work several times each day asking if she felt nauseated or sick. This had been a daily routine until the day of admission when, perhaps in suggestible response, the nausea and vomiting had become severe.

The patient was discharged the following day, and I did not see her or her husband again. I have since regretted this inasmuch as I later learned from the patient's attending physician that when the patient went into prodromal labor at term her husband, an asthmatic, went into status asthmaticus and died.

MANAGEMENT

Having dwelled at such length and in such a fashion upon the emotional issues which complicate pregnancy, I am sure that many of you by now have me pegged as something of a psychochondriac. Certainly the cases presented have been highly unusual and their resolution atypical. Nevertheless they were purposely chosen to illustrate in a rather dramatic way the potential influence of emotional

factors in pregnancy. This is not to say that emotional complications of this order are frequently met with nor that the obstetrician should become a practitioner of analytical psychotherapy. Far from it. The vast majority of emotional problems connected with pregnancy can and should be handled by way of the old fashioned doctor-patient relationship. For this to work, however, there must be a good relationship, and such a relationship to be truly meaningful entails time, interest, and effort on the part of the doctor.

Too frequently have I met with emotional complications which have been aggravated if not produced by hurried obstetrical predecessors—not to be somewhat evangelical regarding this subject. Time and again I have had occasion to see the habitual aborter who, having been told that her miscarriages were due to a series of blighted ova, becomes phobic over the prospect of pregnancy and an anomalous child. In this connection I have yet to see the postabortal patient who was reassured by her obstetrician's statement, "Perhaps it is just as well, since miscarriages are nature's way of taking care of defective babies." Instead, such a statement is usually agonized over and in subsequent pregnancies is put to ominous, self-torturing use. In the same way it is my belief that any speculative diagnosis which is uncorrectable, such as an immature womb or morphologically abnormal sperm, should

be avoided. In this sense I am a kindred spirit to the dermatologist who was confronted by a patient with a strange skin disease. After having had the patient strip and after having examined the patient's skin under natural and ultraviolet light he asked, "Have you ever had this before?" When the patient replied that he had, the dermatologist's reply was, "Well, you've got it again."

CONCLUSION

By way of conclusion, suffice it to say that if maternity care is to be truly comprehensive the doctor must know something of the personality makeup of his patient and something of the psychosocial context in which the pregnancy has developed. Such knowledge can be gained only by getting to know the patient as an individual. In this way, and in this way only, can he hope to understand, prevent, or effectively deal with any of the abnormal emotional reactions associated with pregnancy. In the same way, he can, by constructively influencing the expectant mother, be of real service to the unborn child, whose mental hygiene begins with the mother's pregnancy.

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PEDIATRIC ALLERGY: ITS ROLE IN PREVENTIVE PEDIATRICS

MAURICE M. HILLMAN, M.D., *New Haven*

BOTH the prevention and detection of disease in its earliest stage are among the great benefits of modern medicine. The allergist and particularly the pediatric allergist and practitioner have the unusual opportunity of applying these benefits in practice.

Among chronic diseases in the United States allergy ranks third in prevalence, heart disease and mental illness taking the two top positions. Because of its chronicity it lends itself to early recognition and preventive treatment. Since it is generally recognized that allergy in adults, particularly asthma, has its roots in early childhood, the pediatrician and

The Author. *Attending Pediatrician, Grace-New Haven Community Hospital; Clinical Assistant, Children's Allergy Clinic, Mt. Sinai Hospital, New York City*

SUMMARY

Pediatric allergy plays an important role in the practice of preventive pediatrics. It is claimed that allergy in children constitutes 25 per cent of the pediatrician's practice. This has recently been substantiated by Crooks et al. and presented at a Pediatric Allergy

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generalist are in a very strategic position to institute prophylactic treatment in early infancy and childhood.

Pediatrics as practiced today is assuming more and more the form of preventive medicine. Such communicable diseases as diphtheria, typhoid fever, scarlet fever and small pox have been almost completely eliminated. Also, since the advent of antibiotics, both the morbidity and mortality in early childhood of meningitis and pneumonia have been tremendously decreased. Today scurvy and rickets are uncommon and toxic vomiting and summer diarrhea are considerably less frequent. These results were obtained largely since the introduction of multivitamins in early infancy and the simplicity of milk preparations together with a safer milk supply. The pediatrician is now mainly concerned with the problems of physical and mental growth of the child, the prevention of infection and the institution of the necessary prophylactic immunization procedures.

What role then may allergy in childhood play in the present day practice of preventive pediatrics? It is now conceded by many pediatric allergists that allergic problems in infants and children play an important part in the practice of preventive pediatrics. Estimates have been made that there are 10,000,000 children under 16 years of age who have some manifestation of allergy, and 2,500,000 of these children have major respiratory allergies in need of treatment.

It is now a common practice for pediatricians to treat children through the age of 16 years, and there are 50,000,000 children in this country. This makes quite a sizable population of children who come under the care of the pediatrician and the pediatric allergist. It is claimed that allergy in children constitutes 25 per cent to 30 per cent of the pediatrician's practice. This has been recently substantiated by Crooks¹ *et al.* and presented at the Pediatric Allergy Section of the American Academy of Pediatrics in New York in October, 1956. As a consequence, the present day pediatrician has to be concerned with such syndromes as infantile eczema, recurrent colds, hay fever, bronchial asthma, perennial rhinitis, urticaria and gastrointestinal disturbances.

It is highly significant to note that Clein,² in a ten year study of 100 allergic children, showed that 82 per cent developed their first symptoms as early as

Section of the American Academy of Pediatrics in New York in October, 1956.

It is a well known fact that from 60 per cent to 70 per cent of infants with atopic dermatitis develop some form of major respiratory allergy between the age of 6 to 10 years. It is also well known that potentially allergic children who have an allergic background and who have repeated upper respiratory infection of allergic origin develop hay fever or bronchial asthma in later life.

It has been the experience of many pediatric allergists as well as myself that when these children are given a complete physical examination including allergy testing, a good percentage of these cases are found to be definitive allergic problems.

These potentially allergic children, when given prophylactic hyposensitization against the pollens and inhalants to which they have been found positive, were relieved of their annoying vasomotor rhinitis. Also this form of prophylactic therapy not only served to prevent asthma and hay fever, but also reduced the frequency of recurring upper respiratory infections.

four months of age; 39 per cent of these children had their first episode by one month of age; and that in 85 per cent of this series of children, major allergies appeared before six years of age. Glaser and McKinney³ reported that 80 per cent of children with a history of atopic dermatitis in infancy developed a major respiratory or other major allergy between the ages of six and ten years.

In an attempt to reduce the incidence of the major allergic syndromes, particularly infantile eczema which is so perplexing to most pediatricians, Glaser⁴ carried out the following study. He gave Mull-Soy to one group of potentially allergic infants and cow's milk to a control group. He found the incidence of atopic dermatitis to be four times greater in the control group fed with cow's milk than in the experimental group fed Mull-Soy from birth.

It is because of the contribution made by Glaser and others in this method of feeding that some pediatricians are now using a cow's milk substitute in feeding their potentially allergic infants from birth and later cautiously introduce other foods such as eggs, cereals and vegetables. There seems to be a tendency on the part of some physicians to introduce solid food too early in infancy. At the present time some allergists believe that there is an

increase in the incidence of allergic diseases under six months of age. One probable reason may be because of the relative immaturity of the gastrointestinal tract which permits unaltered protein substances to pass through the mucous membrane of the gastrointestinal tract.^{5,6}

During infancy, next in order to atopic dermatitis, the common infantile allergic syndromes that the pediatric allergists and the pediatricians have to contend with in their everyday practice are those pertaining to the gastrointestinal tract. These are: pylorospasm, colic diarrhea and vomiting. Clein⁷ reported evidence of allergy to cow's milk in 209 babies and found the following distribution of symptoms: pylorospasm 39 per cent, colic 29 per cent, diarrhea 23 per cent. Cooke⁸ cited a series of cases with severe diarrhea, bloody stools and vomiting due entirely to cow's milk sensitivity. Dees,⁹ discussing milk allergy, recently established from a study of 109 patients with an allergic background that 33 of these babies were milk sensitive, causing eczema, gastrointestinal symptoms, upper respiratory infection and bronchial asthma.

From the above facts it would appear that the possibility of cow's milk sensitivity should be given serious consideration by the pediatrician. The trial change from cow's milk to Mull-Soy or other soybean preparation for 24 to 72 hours might, in many cases, help him to solve some of the perplexing gastrointestinal problems of early infancy.

In children of preschool age and older we are mainly concerned with symptoms referable to the respiratory tract: namely, the allergic cold and cough, perennial allergic rhinitis and the incorrectly termed "asthmatic bronchitis," which is in many respects true bronchial asthma. Here, while food still plays some part in the cause of these symptoms, the important causal factors are pollens, inhalants, animal emanations and bacterial infection.

Of the above syndromes, the allergic cold and cough are the most common and the most troublesome that come to the attention of the physician. The frequent complaints of the mother that one hears is "that the child gets one cold after another; that his nose runs constantly, his nose itches and that he sneezes especially upon arising in the morning." The tight, croupy and barking cough that the child gets so often following these colds is now conceded by many authorities to be of an allergic origin. In many instances these are the precursors

of manifest bronchial asthma. Many infants and children will have these allergic colds periodically in the spring and fall, and these are due in many instances to the pollen prevalent at that time of the year.

Pediatricians and pediatric allergists should be alerted, when taking a history of these cases and try to determine whether allergy is the causative factor of these upper respiratory symptoms. After a painstaking and complete study which should include a thorough physical examination, allergy testing and necessary laboratory tests, one will find in a good percentage of these cases that he is dealing with a definitive allergic problem.

It is in this area that the pediatrician should apply his special allergy training and advise the parents to institute the necessary prophylactic measures. These instructions pertain to proper environmental precautions, such as avoidance of over exposure to dust in the home, the elimination of pets and animals, and the avoidance of over exposure to drafts, inclement weather and physical overactivity. No time should be lost in starting hyposensitization treatment if the development of a full blown case of hay fever and bronchial asthma is to be prevented. In advising such immediate treatment, I refer particularly to the children who are skin test positive to pollens without clinical symptoms of pollinosis.

In the prophylaxis of allergic disease in these potentially allergic children, the most challenging thought, and the one which spells definite progress in the field of pediatric practice is the institution of hyposensitization treatment in early childhood. This form of preventive treatment appears to be an advisable and a logical type of therapy, since it has been established by a number of allergists,¹⁰ that 50 per cent of children with pollen hay fever eventually develop bronchial asthma. Such prophylactic treatment has been practiced by a number of pediatric allergists and has been successful in that either very minimal or no symptoms of pollinosis developed in these children. Such pollen prophylaxis has been routinely used in several pediatric allergy clinics.¹¹ By prophylaxis is meant the hyposensitization to pollen and inhalant factors as well as environmental prophylactic supervision.

In support of my contention that the prophylactic treatment in children with an allergic background and who have repeated upper respiratory infections of allergic origin, it is not only feasible, but practi-

cal, I should like to present a preliminary report on 42 children ranging in age between 2 and 16 years. The most common symptoms present were recurrent upper respiratory infection of allergic origin and vasomotor rhinitis. The duration of treatment was from three to five years and freedom from symptoms three to ten years. Out of this number of cases, only two developed pollen asthma and four pollen hay fever.

The number of cases presented is small, nevertheless the results obtained are significant and imply that early prophylactic treatment is a worthwhile procedure. This form of therapy not only serves to prevent asthma and hay fever, but it also aids in relieving the children of their annoying vasomotor rhinitis and reduced the frequency of recurring upper respiratory infections.

It is recognized that a control group of the same number of children would have made these observations more convincing. Since this was not feasible, I have accepted the statistical data surveyed in the field of allergy.^{12,13} Time alone and the compiling of more statistical data will enable us to evaluate the efficacy of this mode of prophylactic treatment of major allergies in potentially allergic children.

In a panel discussion which took place in Mt. Sinai Hospital in 1955, in conjunction with the Post Graduate Course presented by the American Academy of Allergy, Peshkin¹⁴ spoke in favor of such treatment. Rapaport,¹⁵ in a paper presented at the American College of Allergists Meeting held in New York in 1956, also strongly advocated this form of therapy in early childhood. Vaughn,¹⁶ in a recent study on allergic problems in the upper respiratory tract, found this form of therapy very effective. Because this form of treatment is not generally used, it is bound to create much discussion and opposing viewpoints.

In conclusion, I repeat that since pediatrics as practiced today is in many respects another form of preventive medicine, and so allergy in children likewise offers a fertile field for the practice of preventive pediatrics. It is therefore incumbent that the pediatrician should at least have a knowledge of the basic concept of allergy practice. He should be given the opportunity to acquire this information during his clinical clerkship and resident training. In this respect it is encouraging to know that some medical schools and more teaching hospitals are adding the subject of allergy to their curriculum.

The adoption of this new policy is due largely to

two factors: (1) the Newly Organized Institute of Allergy and Infectious Diseases of the National Institute of Health of the U. S. Public Health Service; and (2) the efforts of the American Foundation for Allergic Diseases, organized and sponsored by the two National Allergy Societies. The Foundation, particularly, is doing a magnificent job in educating the public on the importance of allergy in our everyday living.

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UREMIA: ITS REVERSIBLE ASPECTS

MORRIS J. SEIDE, M.D., *Hartford*

UREMIA is usually not the hopeless situation it might appear to be at first evaluation. Many contributing factors may be reversible and adequate renal function can often be restored. Even in advanced nephritis, renal decompensation can be partially reversed^{11,12} if treatment is individualized. This paper will review the reversible factors which are commonly encountered. Several comprehensive reviews are available if more detail is desired.^{8,19,36,37}

The term "uremia" literally means substances present in the blood which belong in urine. The elevated nonprotein nitrogen (NPN) in itself is not harmful but is an index of kidney function. One half to three fourths of total kidney substance must be removed before the NPN rises above "normal" and two thirds removed to seriously impair concentrating ability. Therefore, if the NPN is elevated, both kidneys must be involved although only one is clinically suspect.³⁰

Even though the kidneys are normal by clinical and laboratory criteria, the NPN may be increased if the quantity of urea offered for excretion is too great, the fluid available for excretion too small, or circulation to the kidneys inadequate. The NPN returns to normal when the deficit is corrected.^{10,23}

CASE 1

Male, 16, in status epilepticus was unable to take food normally. He was fed a high protein, high calorie, liquid diet by stomach tube, total liquids 2,500 cc. daily. Urine output remained adequate but his NPN, serum sodium and serum chloride became greatly elevated. Charted intake and output were adequate, but he obviously had inadequate water to excrete the solutes. When protein content in the tube feeding was reduced the NPN, sodium and chloride rapidly returned to normal.

In chronic renal disease, parenchyma may be slowly and progressively destroyed although no symptoms appear until the renal reserve is exhausted. Failure then appears and rapidly progresses although the rate of destruction may remain the same or actually be arrested. Each small increment

The Author. *Senior Resident in Medicine, Hartford Hospital, Hartford, Connecticut*

SUMMARY

Factors, amenable to correction, which may contribute to uremia, are reviewed and their therapy outlined.

Salvage of a few nephrons may mean the difference between progressive, rapidly advancing uremia or renal compensation for months or years.

of kidney tissue then becomes vitally important. A few nephrons restored may mean the difference between life and death. Close attention to minute details may change an apparently terminal case to a fairly comfortable, functioning individual. A thorough clinical and laboratory search should be undertaken for contributing factors which may be reversible. Specific entities to be considered are listed in Table I.

TABLE I
REVERSIBLE CAUSES OF RENAL INSUFFICIENCY
(Modified after Epstein¹¹)

Congestive heart failure	Hypercalcemia:
Infection:	Sarcoid
Pyelonephritis	Milk-alkali syndrome
Bacterial endocarditis	Vitamin-D toxicity
Systemic infection	Hyperparathyroidism
Dehydration	Gout nephropathy
Hyponatremia	Anemia
Potassium depletion	Acute renal failure
	Acute glomerulonephritis

Congestive heart failure furtheres renal insufficiency by reducing circulation to the kidneys.^{46,50} Even in otherwise normal kidneys, heart failure

alone may lead to an NPN of as much as 90 mg. per cent, albuminuria, cylindruria, and hematuria. In borderline compensated renal disease, uremia may become progressively more severe. Therapy should include digitalis, bed rest and perhaps oxygen therapy. Mercurial diuretics are not contraindicated but must be carefully prescribed. Salt restriction may help but must be closely supervised because these damaged kidneys are inefficient in conserving salt. Ammonium chloride must be used with utmost caution, if at all, because acidosis may be easily induced or intensified. The extra nitrogen will also cause a further rise in the nonprotein nitrogen.

Pyelonephritis is obviously dangerous and rapid control of infection need not be emphasized.⁶ However, it is not generally appreciated that active infection may be present for years without fever, chills, leucocytosis, dysuria, or costovertebral-angle tenderness. Pyuria may or may not be present and bacilluria may be intermittent.

CASE 2

Male, 47, with anemia for 4 years, requiring multiple transfusions, was referred for diagnostic work-up. Examination revealed only a chronically ill man with a palpable spleen who had a normochromic, normocytic anemia. Urine was normal with specific gravity 1.010, NPN 200 mg. per cent, and culture of a clean voided specimen grew enterococcus. Further history was then obtained, revealing a "kidney infection" 20 years previously. The attending urologist reported enterococcus had also been cultured at that time. Subsequent course was progressively downhill, in spite of antibiotics.

Every patient with chronic renal disease is entitled to culture of a fresh, clean voided urine. The most reliable method is serial dilution and pour-plate culture. Gram stains of fresh urine are often helpful. Once established, infections are difficult to eradicate. Pyelonephritis should be prevented by avoiding catheters and urologic manipulation unless absolutely necessary. An indwelling catheter almost always leads to infection. Prophylactic antibiotics may not be prophylactic at all but merely change the organism to one resistant to the antibiotic.

Subacute bacterial endocarditis (SBE) may present as renal failure because of mycotic emboli as well as diffuse glomerulonephritis. Heart failure may contribute. The nephritis may be completely reversed if the endocarditis is cured. SBE should be considered more frequently in the differential diagnosis of kidney failure.

Systemic infections, starvation, fever, injury, hyperthyroidism, and most trauma may be disas-

trous. Ordinarily these may be benign but in the presence of borderline renal compensation, they must be corrected rapidly to forestall further decompensation.

Dehydration commonly leads to deterioration in patients with chronic renal disease and may institute a cycle of nausea and vomiting leading to further dehydration, further renal decompensation, and further nausea and vomiting. Encouraging fluid intake may prevent this sequence. Fluids should never be withheld for overnight concentration tests or other laboratory determinations, including blood chemistries. Obligatory nocturnal polyuria will rapidly dehydrate these patients. If oral fluid must be withheld, intravenous fluids should be given. Early morning nausea and vomiting, so common in patients with decompensated renal function, may often be overcome by having tea, milk, crackers, or cookies available at the bedside to be taken immediately on waking.

Electrolyte abnormalities, especially when superimposed on chronic renal disease, may lead to further renal insufficiency. Hyponatremia is especially prone to develop because the damaged tubule cells do not reabsorb sodium efficiently. The so-called "salt-wasting nephritis" is not a specific renal disease but a manifestation of renal insufficiency, regardless of etiology. Hyponatremia alone may cause circulatory collapse and lead to an NPN of 50 to 100 mg. per cent, even if the kidneys are normal. Such situations may be prevented by ensuring the intake of sodium. Salt may be added at the table, or, if necessary, salt tablets prescribed, preferably with meals to avoid gastric irritation and vomiting. To correct hyponatremia, intravenous hypertonic sodium chloride may be necessary.

Alkalosis may decrease renal function. It characteristically occurs after large amounts of sodium bicarbonate are taken by patients with peptic ulcers, especially if these patients also have gastric retention and vomiting. Renal function slowly returns to normal if the alkali is stopped. This effect of alkalosis on renal function may be related to the decrease in serum potassium which is almost an invariable accompaniment of alkalosis.

Potassium depletion alone may lead to renal parenchymal lesions, dehydration, alkalosis, decreased serum chloride, increased serum carbon dioxide, and increased NPN. The urine remains acid and the specific gravity usually becomes fixed.^{1,38,41,49}

CASE 3

Female, 68, had several loose watery stools daily for three years. One week before admission the diarrhea increased considerably, she became weak and unsteady, appetite decreased and polydipsia, polyuria and nocturia appeared but without urgency, frequency or dysuria. There was no past history of kidney abnormality.

On examination she was acutely ill, dehydrated, blood pressure 105/50, pulse 100 and regular, temperature normal, and respirations 20. Fecal masses were palpable throughout the entire colon but the rectum was empty. Stools were liquid, brown, 2 plus benzidine positive, and negative for ova and parasites. Hematocrit was 41 per cent, sedimentation rate 72, WBC 42,000, 92 per cent polymorphonuclear leucocytes. The initial urine specific gravity was reported as 1.031 but subsequent specimens ranged between 1.005-1.011. The urine was acid and contained 1 plus albumin, rare WBC and no RBC. Serum sodium was 120, potassium 2.9, chloride 57, and carbon dioxide 30 mEq./L., NPN 224 mg. per cent, serum calcium 9.0 and phosphorus 3.5 mEq./L. PSP excretion was 35 per cent in one hour and an intravenous pyelogram showed only delayed dye excretion.

After vigorous therapy with fluids, hypertonic saline and potassium, the NPN and WBC returned to normal. Hematocrit was then 25 per cent and corrected to 36 per cent by two transfusions. She was found to have redundant sigmoid colon and adenocarcinoma. Both were surgically corrected.

Ammonium chloride and/or Diamox, especially in patients with impaired kidney function, may lead to acidosis, azotemia and even coma.⁴³ The diagnosis may be difficult and will usually be missed unless specific inquiry is made.

Hypercalcemia leads to kidney damage because stones form in the lower urinary tract with subsequent obstruction and infection and because of nephrocalcinosis with deposits of calcium in cells of the collecting and distal tubules and interstitial tissue. Vitamin D intoxication fortunately is now less frequent, since it is in disrepute as treatment of rheumatoid arthritis. When present it may be corrected by stopping the vitamin D and decreasing the intake of calcium. Kidney function may or may not then improve. Hyperparathyroidism is treated by resecting the adenoma, if it can be found.^{2,29} Dramatic results have been reported in sarcoidosis following treatment with steroids, completely reverting abnormal kidney function to normal in several cases.^{3,9,15,35,40} One patient had a blood-urea nitrogen of 162 mg. per cent before therapy which returned to normal after therapy. The milk-alkali treatment of ulcer not infrequently leads to impaired kidney function.^{20,39}

CASE 4

Male, 57, had a proven duodenal ulcer. Renal function was good and his NPN was 35 mg. per cent. After eight

days of Sippy diet (12 Gm. of calcium daily) he developed polyuria, thirst and stupor. NPN at this time was 143 mg. per cent, urine contained RBC, WBC, casts, albumin, and the specific gravity was fixed. Serum calcium was 16.5 mg. per cent. Calcium intake was stopped and sodium chloride given intravenously. Mental clearing was dramatic. Three weeks later his NPN was 35 mg. per cent, serum calcium normal, and renal function again normal. (Case previously reported.¹²)

Hypercalcemia may also be due to prolonged ingestion of calcium.¹⁸

CASE 5

Female, 49, had extreme weakness, muscle cramps, and insomnia for three weeks. She had had one-time nocturia for one and one half years following one known episode of genito-urinary infection, but no other urinary symptoms. Past history revealed a thyroidectomy 30 years previously. Shortly after operation she was told her parathyroid gland was "not working properly" and since then large amounts of calcium have been prescribed daily. The exact amount taken is unknown but apparently varied between 1 to 2 Gm. calcium lactate daily, and up to 12 Gm. calcium gluconate daily.

Physical examination was noncontributory. Hematocrit was 39 per cent, sedimentation rate 59 mm./hour (Westergren); urine alkaline, specific gravity 1.010, albumin 2 plus, occasional WBC and coarse granular casts; NPN 56 mg. per cent, serum calcium 12.5 to 14.0 mg. per cent, phosphorus 4.0-4.8 mg. per cent, urinary calcium excretion 350-450 mg./24 hours, urine culture sterile; PSP excretion, none in 15 minutes, 8 per cent after 60 minutes; intravenous pyelograms normal, with no delay in dye excretion.

Calcium was stopped and a low calcium diet prescribed. Slowly the serum calcium and urinary calcium excretion decreased, with a gradual return of renal function toward normal. Six months later, serum calcium was 9.6 mg. per cent, phosphorus 3.8 mg. per cent, urine calcium excretion 65 mg./24 hours, NPN 29 mg. per cent, and PSP excretion 10 per cent in 15 minutes, 20 per cent total in 60 minutes. Appetite had improved, she had gained weight, and was subjectively much improved.

Gout usually is accompanied by kidney damage due to urate deposits.^{13,34} Occasionally signs of renal decompensation may precede the joint abnormalities. Probenecid has been reported to reverse both the renal insufficiency and the joint abnormalities. The combination of gout and renal dysfunction should suggest the possibility of urate deposits in kidney parenchyma.

However, in both gout and hypercalcemia the mineral deposits induce irreversible damage to a variable degree. These kidneys cannot be returned to normal, but adequate function may result when proper therapy is given.

Anemia is a frequent complication of uremia.^{4,24} The mechanism is unknown, although hemolysis and bone marrow depression both contribute. At-

tempts at correction are usually fruitless. Other factors, such as blood loss, should be investigated and corrected if possible. The anemia may lead to further uremia and further decrease in renal function, thus to further anemia. The best therapy for anemia secondary to uremia at present is repeated small blood transfusions, not to "normal" but to the point of minimal symptoms.

Obstruction of urinary outflow is a common cause of renal insufficiency which may be reversible if the obstruction is relieved.³¹ Even hydronephrosis and pressure atrophy may be partly reversible. What seems to be obstruction, occasionally may only represent inability to empty the bladder while lying in bed. Every elderly male should be given the opportunity to stand at the bedside to initiate micturition. Catheters should be avoided if possible.

Benign overgrowth of the prostate is obvious as a cause of obstruction.

CASE 6

Male, 73, had slow stream, nocturia, and incontinence for five years. Digitalis and mercurial diuretics had been prescribed for these symptoms. Abdominal girth progressively increased and dyspnea became pronounced. Admission blood pressure was 200/100, pulse 100, lungs clear, heart normal. A huge abdominal mass was palpated. Rectal examination was deferred. Hematocrit was 27 per cent, WBC 12,000, NPN 158 mg. per cent, carbon dioxide combining power 9 mEq/L. When catheterized, the bladder yielded 4,000 cc. of urine. In spite of vigorous therapy, the NPN rose to 170 mg. per cent and he expired. Necropsy revealed considerable prostatic hypertrophy, hypertrophy and dilatation of the bladder, hydroureters, hydronephrosis and bronchiolitis. No other abnormalities were found.

This case epitomizes the end result of untreated urinary tract obstruction. The outcome would probably have been different if treatment had been instituted earlier. A less common cause of obstruction is illustrated in the next case.

CASE 7

Negress, 47, had no urine for two days but looked well. Blood pressure was 160/90 and NPN 180 mg. per cent. She was moderately obese but physical examination and other laboratory work were normal. Initial impression was acute renal failure, unknown toxin, which was apparently confirmed when spontaneous diuresis began two days later. After five days of diuresis, anuria again suddenly developed. Cystoscopy showed both ureters to be occluded. Bilateral ureteral catheters allowed a massive diuresis and the NPN returned to normal. Laparotomy revealed bilateral fibrous strictures of the ureters which were released. Recovery was uneventful. (Case previously reported.¹²)

Acute glomerulonephritis and *acute renal failure* (acute tubular necrosis, lower nephron nephrosis)

are self limited causes of renal insufficiency. Given the necessary time for recovery, the kidney damage will resolve in most cases.^{14,32,44,47} In hospital practice, acute renal failure usually follows shock during surgery, transfusion reactions, severe dehydration or severe electrolyte abnormalities.²⁷ In most cases the precipitating incident could have been avoided. Causes of acute renal failure are listed in Table II.

TABLE II
CAUSES OF ACUTE RENAL FAILURE
(Oliver, *et al.*,³³)

- Ischemia:
 - Severe, acute blood loss
 - Incompatible transfusions
 - Massive, acute hemolysis
 - Myoglobin, crush injuries
 - Prolonged shock
 - Dehydration
 - Electrolyte abnormalities
- Toxins:
 - Carbon tetrachloride
 - Chloroform
 - Diethylene glycol
 - Poisonous mushrooms
 - Sulfonamides
 - Bichloride of mercury

Typically, urinary flow diminishes greatly within a few hours. Rarely, oliguria may be delayed and some patients may even have initial polyuria, without oliguria, accompanying a rising NPN. The clinical course depends on the severity and the individual response to the injury, the extent of lost function and duration of lost function. Incorrect management may contribute to a fatal outcome. Therapy must maintain the patient in good condition until healing occurs and diuresis ensues. The damage may resolve and recovery may be complete if the patient does not die in the interim.

The pathogenesis of acute renal failure is now well documented.²⁵ Oliver, *et al.*,³³ dissected individual nephrons from kidneys of patients who died in acute renal failure, revealing lesions which would ordinarily have been overlooked. The defects could be divided into nephrotoxic and disruptive-tubulorhexic lesions; the nephrotoxic lesions causing desquamation and death of tubule cells but no rupture of the basement membrane, the disruptive-tubulorhexic causing desquamation, death of tubule cells and disruption of the basement membrane. If the basement membrane was intact, the regenerating epithelial cells could reline it, thus restoring tubular function and structure. If disrupted, regen-

erating cells had no surface for realignment, the tubule could not be reformed, and repair was impossible. The gap becomes filled with granulation tissue and the lumen remains obliterated. Obstruction at one point or persistence of even a minute hole prevented functional integrity of that nephron. In disruptive damage, adequate renal function eventually depends on those nephrons spared total rhexis in the original damage.

A diagnostic dilemma is frequent: a patient shows little or no urine for several hours after a complication which might have produced acute renal failure. If the patient is dehydrated, in shock, has hyponatremia or hypokalemia, correcting these factors may correct the oliguria and solve the problem. If no abnormality is apparent, 1,000 cc. of 10 per cent glucose in water probably should be given intravenously, over a one hour period. If urine excretion is still not adequate, stop and begin therapy for acute renal failure. The kidney cannot be "forced open." This erroneous concept is a frequent iatrogenic cause of death.

No food or fluids should be given orally since nausea and vomiting becomes a major problem. Resulting electrolyte problems may be impossible to correct. Intake should be entirely by vein, preferably by an indwelling polyethylene catheter introduced through a superficial arm or leg vein and advanced until the tip lies well within the inferior or superior vena cava. Fluids should be given as a slow, continuous drip of 50 per cent glucose, totalling 400 to 500 cc. in 24 hours, plus the amount excreted in feces and urine. The patient should be weighed daily and weight should decrease by 200 to 400 Gm., about one fourth pound daily.

An indwelling badder catheter is rarely necessary during the period of oliguria, since bladder capacity is usually limited to 300 cc., at which time discomfort is manifest. Daily percussion and palpation of the pelvis and examination of bed-clothes for incontinence will usually indicate beginning diuresis. At this time, accurate account of excretion is mandatory.

Antibiotics, if necessary, should be used with caution, since most are excreted through the kidneys. If excretion is prevented during oliguria, serum concentrations may reach dangerous levels.

The NPN may continue to rise even after diuresis has begun, but this should be no cause for alarm. The danger lies in potassium toxicity. Once the

serum potassium is elevated, serial electrocardiograms are the most reliable guide to increasing toxicity. Intravenous hypertonic glucose with insulin may temporarily reverse acute potassium intoxication. The process of glycogenesis transfers potassium ion into the cells, reducing the serum level. Cation exchange resins are difficult to manage; oral administration may lead to nausea and vomiting, rectal administration is difficult, and either method may induce severe electrolyte abnormalities. Peritoneal dialysis^{17,45,48} has been reported but such procedures are contraindicated in recent abdominal surgery and in the presence of peritonitis. Repeated exchange transfusions¹⁶ reportedly can decrease the NPN and correct acidosis, but are probably ineffective in most cases. Intravenous infusions of 10 per cent calcium gluconate may relieve the cardiac irritability due to acute potassium intoxication. Probably the most effective therapy is to alleviate the acidosis with sodium bicarbonate or sodium citrate.

The artificial kidney will reduce serum levels of potassium and NPN, and eliminate abnormal serum constituents.^{5,21,22,26} If, during the early phases of oliguria, serum potassium is already elevated, arrangements should be made for the use of an artificial kidney because fatal levels may be reached before diuresis occurs. Most patients can be safely carried through oliguria without an artificial kidney.

A most important therapeutic principle is to avoid overhydration since the resulting dilution leads to hyponatremia and may lead to congestive failure.²⁸ However, fear of overhydration must not deter the physician from adequate therapy of dehydration. Once overhydration has been induced, it is best left untreated if possible, since hypertonic sodium almost invariably leads to acute congestive failure.

TABLE III

TREATMENT OF ACUTE RENAL FAILURE

- Nothing by mouth.
- Daily fluids: 500 cc. 50 per cent glucose by indwelling intravenous polyethylene catheter.
- Weigh daily: Daily weight loss, 200 to 400 Gm.
- Accurate intake and output.
- No indwelling bladder catheter.
- Antibiotics, cautiously, if at all.
- For potassium toxicity: Glucose infusions, insulin, cation exchange, peritoneal dialysis, artificial kidney.
- For heart failure: digitalis.

in this situation. Occasionally, hyponatremia must be treated, to correct hyperpotassemia. The entire

difficulty can usually be avoided by precautions against overhydration. Occasionally, congestive heart failure occurs without evidence of overdilution or electrolyte abnormality. Digitalis should always be tried, but has not always been successful.

During recovery and diuresis, urine volume increases, without any sudden or profound change in tubular structure. Blood flow to glomeruli, thus filtration, improves before tubular function improves. Most of the filtered portion therefore is excreted and as filtration increases, so does the excreted volume. Only a few nephrons and relative-

ly little filtrate are required to produce a large urine volume with the specific gravity and constituents of plasma. As tubule function returns, the urine again can be concentrated and urine volume decreases. During the diuretic phase, adequate fluid and electrolyte replacement are mandatory.

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NEONATAL PULMONARY TUBERCULOSIS

A Diagnostic Problem with Report of a Case

RAYMOND B. KEEFE, M.D., *Windsor*

UNTIL recently pregnancy has been regarded as uncommon in the presence of pelvic tuberculosis. Reports of Kendig¹ and Chapman² have emphasized that pregnancy not only occurs but often results in viable births. Neonatal pulmonary tuberculosis via amniotic aspiration and/or exposure is a possible hazard in all such births. Other important etiological factors are the size of the infecting dose, the virulence of the organisms and the degree of maturity of the infant. This form differs from the congenital variety in that it does not involve placental transfer with a primary hepatic complex.

Grady³ states that the classical major diagnostic criteria—such as positive Mantoux tests, characteristic radiographic changes, and demonstrable organisms—are late and often absent signposts on the road to diagnosis in early infancy. The immaturity of the immunological mechanism in an essentially anergic individual makes for inadequate body defense and tissue response. These factors lead to peculiarities and variations in the clinical picture of this disease.

Special criteria are postulated as guides in diagnosing neonatal tuberculosis. The usual symptomatology, acute and severe in onset, follows upon a relatively asymptomatic period. The *sine qua non* of diagnosis is an awareness of a history of tuberculous disease in the mother or family. Once the possibility of tuberculosis is known to exist, the

The Author. *Formerly Resident in Pediatrics, St. Francis Hospital, Hartford, Connecticut*

SUMMARY

Attention is called to the difference between congenital and neonatal pulmonary tuberculosis. The clinical picture of the latter is evidenced by its variations and peculiarities and guides in making the diagnosis are offered. A single case report is included together with the results of investigative studies on the mother, all pointing to the importance of early diagnosis and treatment.

physician can be alert for compatible but not necessarily diagnostic radiologic changes. Finally, during the "asymptomatic" period the infants should be checked for subtle variations in temperature, appetite and activity.

The following case report describes the clinical course, laboratory results and autopsy findings of a newborn infant along with pathological reports of maternal tissues. The diagnosis in this case was made at postmortem examination. In retrospect the clinical picture demonstrates the validity of the diagnostic criteria stressed by Grady.³

Case R. A. was a 5 lb. 6 oz. white male premature infant with an estimated gestational age of eight and one half months. The mother was a 39 year old gravida 10, para 7,

abortion 2, Rh + female whose admission chest photoroentgen was negative. The mother's membranes had ruptured two days prior to delivery, and the delivery was sterile and spontaneous. The initial physical examination of the infant consisted of normal findings. The nursery course was that of a slow feeder who failed to gain weight. Intermittent tube feedings were required because of poor sucking activity, and the baby at two weeks of age weighed five ounces less than its birth weight. There was also a history of irritability and an immoderate amount of crying. At ten days of age a mild oral thrush was diagnosed and treated for two days locally with one per cent aqueous gentian violet. On the 18th day of life a sudden temperature spike to 100.4° was accompanied by an ashen gray color. Respirations were described as rapid, shallow and irregular. No rales were heard at this time, but a chest x-ray done that day was reported as showing bilateral diffuse nodular infiltration of both lung fields extending to the peripheries (Figure 1). A blood culture was drawn and was negative. The WBC was 16,500 cc/mm with 72 per cent polys in the differential. The infant was placed in O₂ with humidity, and streptomycin and penicillin were started by intramuscular injection. The following day wet rales were heard throughout both lung fields. The clinical impression at this time was diffuse bronchopneumonia, either of a bacterial or a fungal etiology. Intramuscular cortisone was started and given over a period of nine days. The streptomycin

was stopped after seven days and the penicillin stopped after eight days. The infant showed remarkable clinical improvement. After four days of therapy the lung fields were clear to auscultation, the fever had subsided, appetite returned, weight gain was instituted and the WBC fell to 9,700. Repeat chest x-rays, however, showed no resolution whatsoever of the previously reported nodular infiltrations. Because of the excellent clinical condition and weight gain, the infant was discharged on the 40th day of life.

Five days later the baby was readmitted to the Pediatric Service. The mother in her history stated that during a feeding the baby began to gasp and became blue. Condition on admission was critical with the infant described as lethargic, flaccid and a pale ashen gray. Respirations were shallow, irregular and rapid. The respiratory rate was reported as being 90 per minute; the ventricular rate, 144 per minute. Wet rales were heard in both lung bases, the spleen was firm and palpable three finger breadths below the left subcostal margin and the liver palpable two finger breadths on the right. The admission chest x-ray showed consolidation in the right chest superimposing the persistent diffuse nodular infiltrations. The WBC was 75,000 with 69 per cent polys, a pronounced shift to the left, and toxic granulations.

The clinical impression was that of a superimposed aspiration pneumonia with cardiac failure. A specimen of blood for culture was again drawn and was negative. Rapid digitalization was started along with O₂, parenteral fluids,



FIGURE 1A

Lateral chest film at 18 days of age

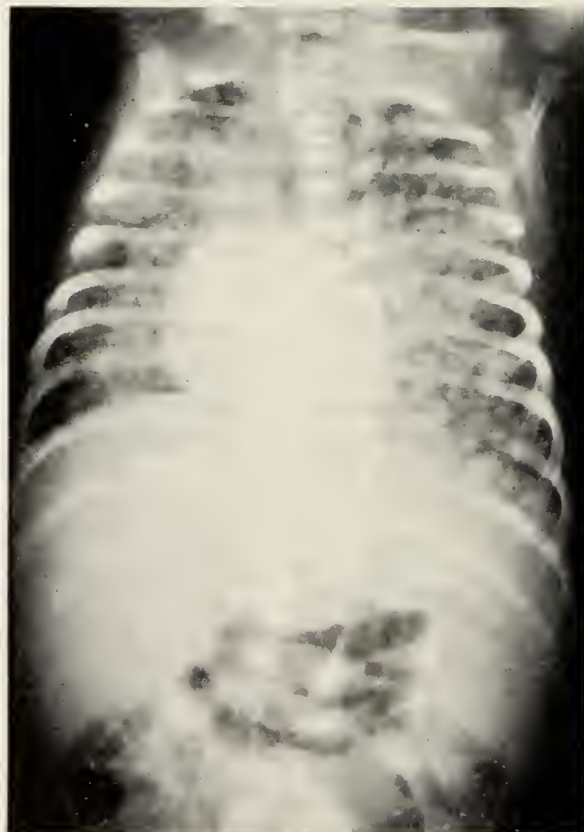


FIGURE 1B

Chest film at 18 days of age demonstrating diffuse nodular involvement of both lung fields

and penicillin and Ilotycin therapy. The hemoglobin on the second day was 12.7 Gms. There appeared to be a response to therapy with liver size decreasing and the lung fields showing evidence of partial clearing. On the third day the infant began to pass tarry stools, and there was a questionable further enlargement of the spleen with a fall of hemoglobin to 9.4. It was felt that the baby had a splenic vein thrombosis, although the etiology other than debilitation was obscure. On the fourth hospital day there was a temperature spike to 102° and an accentuation of the respiratory distress continued unabated. From this point the infant ran a progressive downhill course and expired on the eighth hospital day which was the fifty-third day of life.

At autopsy a diffuse bilateral nodular infiltration was found along with hilar lymphadenitis. The lungs weighed 200 Gms., were overexpanded, extremely hard and virtually airless. The entire pulmonary parenchyma had been replaced by a diffuse infiltrative process characterized by the presence of firm round nodules which measured about 5 mm. in diameter. The nodules had a creamy yellow color, some having evidence of central necrosis. Microscopic smears of the nodules showed profuse numbers of acid fast tubercle bacilli.

There were no significant adhesions or fluid accumulations within the abdominal cavity. The gastrointestinal tract was unremarkable. The spleen was enlarged, weighing 35 Gms. with an infarct. Loculated accumulations of bloody fluid were noted beneath the splenic capsule. There were no nodular lesions of the spleen similar to those found in the lung. The liver was enlarged but was otherwise unremarkable. The kidneys were congested but otherwise normal.

A microscopic examination of the lungs showed nodular lesions characterized by central necrosis and peripheral fibroblastic proliferation. Epithelioid cell production was minimal and only a rare giant cell was seen (Figure 2). Acid fast stains showed myriads of typical tubercle bacilli within the necrotic lesions. The intervening recognizable lung tissue was atelectatic. The hilar lymph nodes likewise showed a similar granulomatous inflammatory process with necrosis and large numbers of organisms. The necrotic area of the spleen proved to be an infarct with no evidence of infiltration. Bone marrow and the remainder of the microscopic examination were negative.

A survey of the family was undertaken, and the parents and seven siblings were found to have negative chest x-rays. A Mantoux test was positive on the mother, while in the remainder of the family it was negative. The mother was admitted to the hospital for diagnostic investigation. Pelvic examination revealed a cervix that was greatly inflamed with pinpoint hemorrhagic spots. There was a 1 x 1 cm. ulcer on the anterior vaginal wall which was excised. Cervical biopsy was obtained and the uterus curetted. On microscopic examination within the stroma of the endometrium were found numerous granulomata characterized by caseous necrosis, epithelioid proliferation and the occurrence of numerous giant cells of the Langhans type (Figure 3). Acid fast stains revealed the presence of bacilli morphologically consistent with the tubercle bacilli. The biopsy of the vaginal mucosa showed the same typical granulomatous reaction of tuberculosis.

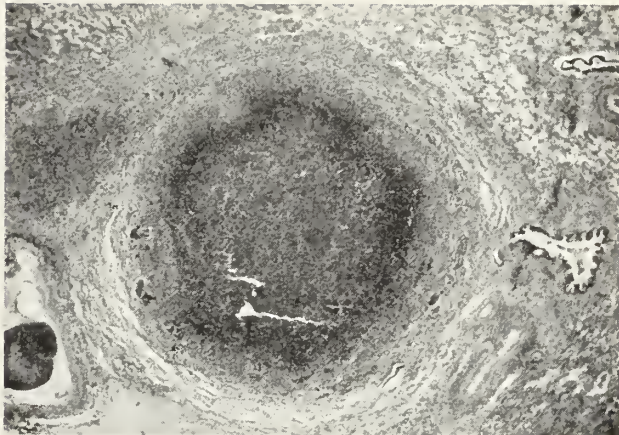


FIGURE 2
Microscopic Section of Infant's Lung. A lung nodule showing necrosis and peripheral fibroblastic proliferation

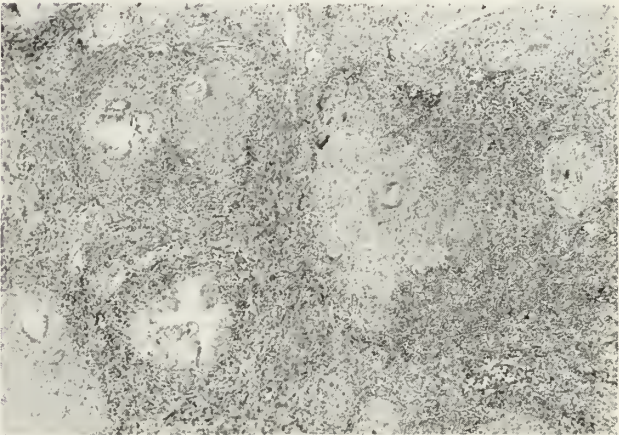


FIGURE 3
Endocervical Biopsy. Granulomata showing caseous necrosis and epithelioid proliferation

CONCLUSION

This case is reported because it emphasizes the importance of prenatal awareness of tuberculosis in the mother or family of a newborn infant. Early awareness and prompt treatment are of more than academic interest. The ever improving antituberculous types of therapy make prompt diagnosis a practical clinical expediency.

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THE PRIVATE PRACTITIONER AND THE PRACTICE OF OCCUPATIONAL MEDICINE

JOHN F. KILGUS, JR., M.D., *Litchfield*

The Author. Chief, Health Services for State Employees, State Department of Health

JUST what one sees depends very largely upon the point from which he looks. It is so with private practice and the practice of occupational medicine. The man in private practice quite naturally sees medical practice in a somewhat different light from the man who devotes all or the greater portion of his time to occupational medicine. There is in reality, however, no great difference in the problems encountered. The differences depend largely upon the point of view. I consider myself very fortunate in having viewed the practice of medicine from two vantage points. For nearly 20 years through the eyes of a general practitioner, and more recently as one employed full time in occupational medicine.

We have heard much from the Russians concerning peaceful coexistence. In the relationship between private practitioner and industrial physician we cannot be satisfied merely with peaceful coexistence. There must be, instead, whole hearted, genuine cooperation. The aims of both groups are identical. We are going in the same direction, following parallel roads. We must not get into the other fellow's traffic lane except by direct invitation or to render assistance to him. We are both governed by the same medical ethics and we will do well to add to this the Golden Rule.

If differences seem to arise, it will be well for us to attempt to see the problem from the other fellow's vantage point. This should not be so difficult since most men in private practice do some type of occupational medicine. Certainly they all treat employed persons, and the problems of their occupation certainly must influence their progress or lack of progress under treatment. Even the gynecologist and obstetrician has the housewife as his patient, and certainly in her occupation as a housewife she encounters occupational hazards similar in many respects to employed persons. A few years ago the Academy of General Practice polled its members

SUMMARY

The author, formerly a general practitioner in rural Connecticut and more recently a fulltime occupational physician, is well qualified to discuss certain problems which arise in occupational medicine involving the private physician and the industrial physician. The first problem discussed is the difficulty encountered by the private physician on the one hand and by the industrial physician on the other in determining the relationship of an employee's illness to his occupation.

Other problems discussed are those involved in the certification of an employee's illness, the choice of a physician in compensation cases, and the immunization of employees in industry.

Instead of peaceful coexistence between private practitioner and industrial physician, whole hearted, genuine cooperation is required. Each should make an honest attempt to view the problem from the other's vantage point.

and found that 94 per cent were doing some occupational medicine.

Let us look at some of the problems that arise, first through the eyes of the private practitioner and then through the eyes of the physician employed in industry.

ILLNESS DUE TO OCCUPATION: THE PRIVATE PHYSICIAN

A patient comes to his personal physician with certain complaints. The physician begins by taking a more or less detailed history and listening to his tale of woe. While he is telling his story, the physician is considering certain possibilities; things he must confirm, or rule out. The physician asks the patient to elaborate upon certain points which have

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struck him as being important. He then begins a complete physical examination, if this seems to be warranted, with special emphasis upon certain points which have been brought into prominence by the patient's history. He adds to this such laboratory work as seems necessary. All this being completed, the physician must come up with some sort of an answer. Sometimes this is easy, sometimes it is difficult, and many times it is impossible. In the course of his history the physician is sure to have inquired into, if he does not already know, the man's occupation. The question then arises as to whether or not the man's occupation is in any way responsible for his complaints. This may be actual, as in a silicosis directly caused by the man's occupation; or his complaints may be largely psychosomatic, influenced by his working conditions, the size of his pay check, the attitude of his foreman, or his fellow workers. The physician then questions his patient more carefully as to his occupation. And you have all, I am sure, experienced complete bewilderment by the man's description of what he does and how he does it and his idea of how this might effect his well-being. How then is the physician going to sort this out and get a true picture of this man's occupational history? If by good fortune the man is employed in an industry where there is good medical control and a competent industrial physician, the logical thing for him to do is to consult this industrial physician. From him he can learn exactly what the man does, under how much stress he works, and not infrequently get a good insight into the man's attitude toward his work and his relations with his boss and his fellow employees. He also can have the benefit of the findings of his pre-employment examination, a detailed history of any occupational injuries or illnesses he may have had, and at least some information as to the nonoccupational injuries and illnesses that may have come to the attention of the medical department. Certainly this cooperation between the industrial physician and the private practitioner can be most helpful to the private practitioner.

ILLNESS DUE TO OCCUPATION: THE INDUSTRIAL
PHYSICIAN

Now let us look at this same problem from the industrial physician's viewpoint. Let us begin with the prospective employee's initial examination, that is, his pre-employment or preplacement examination. The man gives the type of medical history

that any layman would give. He is very vague and utterly confused on certain points. The examining physician may feel that this man is unemployable or because of certain points in his history must be limited in the type of work that he can perform. In justice to this man and in justice to the company employing this physician, he must ascertain the true facts. Where is he going to get them? From the man's personal physician, the one who has performed the surgery, who has cared for him through the previous illnesses which he so vaguely describes. This may change the whole picture. The industrial physician learns that what he suspected to be a malignancy was not. That the lung condition he described was not tuberculosis as he suspected, in fact it really didn't amount to anything. The reverse of course may be true, and he may find that certain points in the history that were glossed over very lightly by the prospective employee were truly of great significance, and that the man must be properly placed in order to keep him from further injuring himself or from being a hazard to his fellow employees. As you can readily see, the one hand washes the other. The industrial physician can be of great help to the private practitioner and to his patient; and the physician in private practice is invaluable to the physician in industry. Close cooperation between the two pays big dividends.

In discussing this matter of history taking and listening to the patient's tale of woe, I am reminded of a true story told me by a Waterbury physician a good many years ago. I have told this story many times over the past 20 years and I am sure that I always get as big a kick out of it as does the person who hears it for the first time, because it hits so close to home. So many times I have been listening to a patient and find that my mind is wandering either to seemingly more important or at least more pleasant matters. The physician who told me this story was a great sportsman, raised English setters, and trained them for hunting. He was meticulous in his training and proud of the excellent results that he obtained. He gave a fellow physician a bird dog as a present. The recipient of this dog was not a very good shot and it seems that he had a couple of friends who likewise were not very true in their aim and the three of them went hunting on the first day of the bird season. They were fortunate in running into a large number of birds. The dog behaved beautifully. He found the birds and pointed them staunchly. Each time the bird was flushed, six

shots rang out and not so much as a feather fluttered to the ground. By noon the dog was very disgusted with this procedure and said to himself, "The hell with this," and went home. Not being able to find the dog, and therefore not being able to find any more birds, the hunters did likewise. Then the owner of the dog confronted the giver of the dog with the dog's trainer and he gave the matter much thought and consideration. He had been hunting all day, came into his office that evening for evening office hours. The doctor related to me that he got through his first few patients with no difficulties and then the mother of a child came in and began talking in a monotone about her little Willy. It seemed that Willy wouldn't eat his spinach and little Willy didn't sleep properly, and little Willy did this, and little Willy didn't do that and so on ad infinitum. During this the good doctor's thoughts turned to this bird dog. And when suddenly, and after some time, the woman stopped speaking, the physician realized that he must tell her something. He hadn't the slightest idea what she had been talking about, but feeling himself quite equal to the occasion, pulled himself together and said, "I think if you shoot over him a few times, he will be all right."

CERTIFICATION OF ILLNESS

Of the other problems that face both groups, one of the most annoying for the private practitioner, I am sure, is this matter of certifying to an employee's absence from work because of illness and attempting to decide when that man is capable of returning to work and to what type of work he is capable of returning. The private physician is frequently behind the 8 ball. The patient comes to him asking for a certificate to return to work. Many times that is the first time he has come to him. The doctor has no idea whether the man was actually sick, whether he was on a drunk, or whether he had been fishing; but, if he is to stay in the good graces of his patient and of the patient's family and friends, he must give him a certificate. So he does the best he can. He is as vague as possible. He avoids stating the man's actual illness. He does not mention the fact that he did actually not attend the man during his illness and in fact he sends that man off with a certificate that means absolutely nothing.

Turn now to the industrial physician's problem. This man comes to him with the medical certificate stating that his absence from work was due to illness. The certificate is vague, the man is still more

vague. Was the man actually sick? Should he be paid for the time he was out? Was his illness of such a nature that perhaps his work should be modified for a time? Is he a menace to his fellow workers? I have been required to write those certificates, I have also been required to pass judgment on the same type of certificate. Many of you have been on both the giving and receiving end of this deal and to you men in private practice I say, the next time you are confronted with this situation, think of the predicament of the industrial physician who is going to receive this certificate. And to you industrial physicians who receive one of these weird certificates, before you fly off the handle, think of the predicament of the poor devil who is confronted with the loss of this patient's good will and that of all his family and friends if he does not come across.

CHOICE OF PHYSICIAN

Another point which frequently irritates is the matter of the choice of physicians in compensation cases. The Connecticut Compensation Law, Section 2285 C reads in part,

"The employer as soon as he shall have knowledge of any such injury shall provide a competent physician or surgeon to attend the injured employee and in addition shall furnish such medical and surgical aid or hospital or nursing services as such physician or surgeon shall deem reasonable or necessary."

This, as you see, puts the responsibility of selecting a physician to treat compensation cases clearly upon the shoulders of the employer. Now this same section of the law goes on to state:

"In the event of the failure of the employer promptly to provide such physician or surgeon or medical or surgical or hospital or nursing service, the injured employee may provide such physician or surgeon or medical or surgical or hospital or nursing service at the expense of the employer, or at his option the injured employee may refuse medical, surgical, hospital or nursing service provided by his employer, and provide the same at his own expense. The commissioner may, without hearing, at the request of the injured employee when good reason exists or on his own motion, authorize or direct a change of such physician or surgeon or such hospital or nursing service. If it shall appear to the commissioner that an injured employee has refused to accept and failed to provide such reasonable medical, surgical, or hospital or nursing service, all

rights of compensation under the provision of this chapter shall be suspended during the refusal and failure."

I do not for one moment deny that there are two sides to this story of choice of physician. The thinking behind this provision of the law is just this: that the employer or the employer's insurance carrier should be in a better position to secure competent medical or surgical attention for an injured worker than the worker himself. This seems more reasonable when you stop to realize that under Connecticut law, if the employee had his free choice of physician he might choose to be treated by a member of one of the various cults, which in this State unfortunately legally prey upon the public. It is certainly not to the advantage of the employer or of the injured worker to have a ruptured disc manipulated by an osteopath or chiropractor. To be sure, this provision of the law has been and probably will continue to be abused by some. Let us, however, look at the matter without prejudice and realize the intent of the law.

We sometimes hear the complaint that the industrial physician is taking bread out of the private practitioner's mouth. That he is treating nonoccupational conditions which should be treated by the private physician. Where there is smoke there is usually fire. No doubt some of these accusations are well founded, but let us not damn all industrial physicians for the errors of a few. Let us be sure that the rumors that have reached us are well founded; and that the industrial physician is actually trespassing on the field of the private physician.

I should like to quote from the *Guiding Principles of Occupational Medicine*, published by the Council on Industrial Health of the American Medical Association. Under the heading of Scope of Service, Section 4, Medical & Surgical Care, Part B.

Non-Compensable Disability:

"The treatment of injuries or disease, non-occupationally induced is the function of private medical practice. The physician in his industrial relation should abstain from such service except in the case of (1) absence of accessible independent facilities, and (2) minor disorders that temporarily interfere with an employee's comfort or ability to complete a shift, for the relief of which he would not ordinarily seek other medical attention."

PROBLEM OF IMMUNIZATION

Last but not least comes the problem of immunization. Under this same section of the *Guiding Principles of Occupational Medicine* from which I have just quoted, is a statement concerning this problem. "Established standards of medical practice in the community shall govern case finding and immunization programs in industry." In other words, they suggest that when in Rome we do as the Romans do. This problem is difficult to settle by any rule of thumb. It seems to me that it is good preventive medicine and that it is sound ethical industrial practice, for example, to immunize laboratory workers potentially exposed to typhoid fever against this disease, or highway workers against tetanus. It is further argued by some industries that immunization against influenza prevents absenteeism and is therefore a logical and ethical procedure of industrial medicine. Whatever these practices may be, I feel very definitely that if they are carried out at all, they should be strictly limited to the employees and not include the employee's family. Actually I believe that the private physician often profits by the publicity attendant upon an industrial immunization program. That is, it brings the problem to the attention of the worker, who in turn sees to it that members of his family receive these immunizations from their family physician.

Recently the Committee on Industrial Health of the State Medical Society was asked to express an opinion as to whether or not the immunization of the employees in an industry against poliomyelitis was the proper function of an industrial physician. This matter was deliberated at length by the Committee on Industrial Health and I will read to you their reaction. Following is taken from the minutes of the Committee on Industrial Health under date of October 24, 1956.

"The chairman reported that he had been requested from several sources to render an opinion as to the propriety of mass polio immunization in industry. The Committee learned that there are a few instances in the state where firms have offered this service. A lengthy discussion of the problem of the polio immunization as well as other immunization ensued. Many viewpoints were expressed. The discussion revealed a unanimous opinion that the immunization for polio was not the function of the physician practicing occupational medicine and that under the provisions in the Code of Ethics relating to occupational medicine, activities such as this were

thought not to be included in the general scope of services. It was therefor moved and seconded that the following statement reflects the opinion of the whole committee on this subject.

"The Committee on Industrial Health of the Connecticut State Medical Society has been asked for a recommendation with respect to the administration of poliomyelitis vaccine by physicians practicing occupational medicine. After careful examination of the medical problems associated with poliomyelitis vaccination, this committee has reached the conclusion that such vaccination should be administered by personal physicians rather than by physicians acting in their capacity of occupational medicine, except in the case of impending epidemic or upon the written request of the employee's personal physician. We believe this to be in the best interest of the patient because his personal physician is best qualified to prevent and treat any possible complications arising out of the use of this vaccine."

I am aware of the fact that I have only skimmed

the surface. I touched only upon the very few of the situations where controversy or a difference of opinion may arise between the industrial physician and the private practitioner. What I would like to bring out is that the modern industrial physician is no longer a plant physician or the company physician whose chief function was the treatment of traumatized employees, but rather a specialist in his own right. Industrial medicine is an increasingly important field and more and more men are being trained and well trained in this field. The industrial physician can and will do a much better job if he has the cooperation of you men in private practice and certainly he is in a position to render you invaluable aid in caring for your private patients who are also employees of the company he represents.

Let us then endeavor to understand each other's problems and to live not merely in peaceful co-existence but rather in a state of whole-hearted cooperation whereby each of us may profit by the knowledge, training and experience of the other.

THE AMERICAN SOCIETY OF INTERNAL MEDICINE

CLAUDE C. CALLAWAY, M.D., *San Francisco, California*

The Author. *Secretary-Treasurer, American Society of Internal Medicine*

SUMMARY

An internist is a physician particularly interested in the diagnosis and treatment of medical diseases, qualified by special training to practice this as a specialty. The present position and the future of the internist in medical practice is emphasized and the need for organization is pointed out. The public, the representatives of consumer groups, and the medical profession as a whole must be the recipients of an educated effort on the part of the organization of internists.

The first group of internists was organized in Cali-

fornia. From this has developed the American Society of Internists. Other medical specialties have similar problems, such as proper remuneration for services rendered. Allies in the field of medicine have been cultivated. Opposition is being offered to all those forces which tend to lessen the quality of medical practice.

THE deliberations and actions of your Society, with those of other groups, all joined in the American Society will surely, and indeed must, have a profound effect on the future of medicine in America. It is this future, and particularly the prospect of the internists that we are met upon, for if our way of practice be extinguished by finan-

Excerpts from address presented at the meeting of Connecticut Society of Internal Medicine, December 11, 1956

cial suffocation, then the quality of medical care our people now enjoy will deteriorate and decline.

It is strange that an able and proud group such as ours needs band itself together in defense. The internist where known is well respected. After the sacrifices of long training, the continual processes of attrition and increasingly difficult examinations, only the most able and enduring, their formal study at end, finally reach the status of internists. What is such a physician?

DEFINITION OF AN INTERNIST

He is one who, through the years of medical school was particularly interested in the diagnosis and treatment of medical diseases, who undertook the special training in residency which would allow him to implement his interests. He is a man who continues his training all through his life, staying abreast of all the advances in medicine, indeed, leading the way. He is one who in practice reserves a minimum of an hour for each new patient, conducting careful inquiry into all phases of the patient's past illness, incidental defects, and familial background; and, gaining understanding of the social factors, psychic makeup, fears and anxieties of the patient, is then prepared to employ with care and discretion all needed x-ray, clinical laboratory and consultative studies, to the end that a precise diagnosis be achieved.

Such a person reserves adequate time for the follow-up visit, explaining where discreet and advisable, the nature of the illness and the treatment projected.

The internist confines his practice to that field in which he was trained, referring problems outside his specialty to those better qualified, thus acting as the modern medical adviser, the personal physician to his patients.

One might expect that such a doctor would enjoy continuing financial security, for his attainments are respected by his colleagues, and his services are increasingly in demand by patients, yet this is not so. His way of practice, and thus his specialty, approach a great challenge of survival.

Curiously, this challenge takes origin from the desirable social goal of providing all persons in this nation with more medical services. In the mechanism towards this goal now achieved by medicine, or that are now proposed by those in a position to plan, advise or demand, the internist has been lost, shut out, forgotten or ignored, in the development

of plans for medical care of our patients on either community, state or national level.

EFFECT OF PREPAID HEALTH INSURANCE PLANS

The first indirect blow arrived with the gradual evolution of prepaid health insurance plans. Herein it was easy to classify the procedures of radiology, or determine how many appendectomies might be performed in a given group. It was possible to place a low fee on an office visit, but there was no ready means of insuring, from an actuarial point of view, the complete history and physical examination, nor the medical consultation. There were none of us there to insist that these essential services be recognized and appropriately compensated. The office visit became by default, the same procedure—whether it were the complete diagnostic survey, or an injection of vitamins given by the office nurse.

The next unwitting, and indeed unwilling, attack on this aspect of the quality of medical care in the United States was delivered, and is now vastly augmented by organized medicine itself. In 1938 the physicians of California were faced with the grave threat of State medical care for a large number of its citizens. The California Medical Association reacted to this threat by creating the California Physicians Service. This instrument, providing low premium, service type, medical insurance to low income groups averted the threat of State Medicine, but the victory was very dear for it established a minimal fee schedule for all physicians, and completely ignored the economic facts of internal medicine. Further, it placed official approval on this substandard compensation. This pattern spread rapidly to other States, now creating the vast Blue Shield complex.

Now that private insurance carriers had learned there was money to be made in group health insurance, and now that instruments of organized medicine were prepared to provide physicians' services, all without provision for the services of the internist, there entered on the scene the large and powerful groups representing the organized consumers of medical services. Coffers swollen with fringe benefit and welfare funds, they demanded global care—at minimal remuneration. Playing one contract against another, private carrier against Blue Shield plan, they succeeded in maintaining fees to physicians at the lowest level in service plans, while complaining loudly of a physician who charged more than the allotted amount in an indemnity-type plan.

There has been little change in this original fee pattern. Though the insurance company pays more and more to the hospital without question, as the costs of hospital care rise, the little medical fee remains the same; there is no cost of living increase, nor rise in fee to meet the mounting costs of giving service.

Not satisfied with the breadth of care their members were receiving, and unhappy from time to time that their members were called on to pay money out of pocket over and above their health insurance benefit, these consumers of medical services employed new instruments to rectify these grievances; they negotiated with closed panel groups to provide complete medical care at less cost than it could be purchased from private carriers or Blue Shield Plans. These closed panel groups were supplemented in some instances by the creation of wholly financed and wholly controlled health centers. In many areas the threat of the creation of such a center forced the physicians of the region into many concessions which were economically unsound, under fee schedules which, if applied to all their practice, would have destroyed either the internist, or completely changed his mode of practice.

I believe we must all admit that if we internists were forced to exist on fees afforded by prepaid health insurance plans, we could not survive. Throughout the nation the internist must make his living on those patients who are either not yet covered by insurance schedules, or who have indemnity type insurance which allows the physician to charge his usual fee.

Gentlemen: our existence then is tenuous. The great groups of organized labor have strongly expressed their demands for complete coverage, full service type plans. They generally accept indemnity insurance only where service plans are not available, or where their fringe benefits are so split amongst health insurance, life insurance and administrative expense, that they can afford only the cheapest indemnity coverage.

The group of people not covered by health insurance, the other segment, wherein we may charge our fair standard fee, is shrinking so rapidly that statisticians predict it may be negligible in many areas within ten years.

In this wild growth of health insurance plans, and the keen competition incident to their sale and acceptance, the internist stands wholly forgotten,

and with him his patient, and the quality of American medicine.

EFFECT OF MEDICARE

Entering now this bleak future of our specialty is the Federal Government, through its first overt acceptance of a fee schedule—in the Medicare program. Although there is a section on special medical services, an outgrowth of the work of the California Society of Internal Medicine, the omission of the complete history and physical examination, the diagnostic study, renders the program unacceptable and offers its beneficiaries substandard care unless you, the Internist, perform these services at the fee for the simple hospital visit. Internists being what they are, I suspect that you will, for you have spent your career in a manner of practice that you cannot now demean. Yet it is not the few million dependents under the Medicare act that concerns us; it is that the pattern has been set, the mold is formed, and our most important service is not recognized.

If this program be successful, it may be extended bit by bit to other groups: federal employees, old age and survivors, all veterans, all unemployed; until finally, bit by bit, we have come into total State Medicine. A moderately severe financial depression or a change in political atmosphere might bring this prospect to pass with great rapidity. Under the present federal scheme only a few internists could find sufficient patients to continue; the rest of us would deteriorate into doing a little of this and a little of that, but all at great speed, if we were to keep body and soul together.

Having become aware of the problem, then we, as internists, must join together and create an instrument which can speak for us, negotiate for us, demand and refuse; for our services are desired by patients and are necessary to the whole of medicine. We should be able to speak from strength.

ORGANIZATION OF INTERNISTS

The first economic organization of internists was the California Society of Internal Medicine. The thirty-six members present at its infancy now are part of a strong and cohesive unit of over 850 members, all qualified internists. This organization has been able to exercise strong influence both in the local medical societies and at the State level. We are able to negotiate with and advise labor groups. Of an original nine point program designed to make our Blue Shield plan acceptable to internists, eight

have been accomplished, and the ninth is under negotiation.

Yet it was soon apparent that there are many areas in which a State society could not be effective. The increasing tendency to negotiate health insurance contracts on a nationwide scale; the amalgamation of great labor organizations; the probability of increasing federal participation in medicine; all suggested that a national organization was now in order. Some of you attended the founding meeting of the American Society of Internal Medicine. At that time there were six State Societies of Internal Medicine; now there are twenty-four, and others are forming.

That meeting, and our subsequent work, have together awakened a recognition of need, so that physicians who feel they belong to too many organizations already are now forming yet another.

Although the American Society is a federation of State Societies, those State groups who shall become members must have set standards for admission that equal those of the national organization. We must be certain that our organizations, State or National, accept only the qualified and the respected. If this standard is maintained, we shall have strength and force when we present our case. If we represent even a fringe not actually acting as internists, we shall fail. It is not enough that a man must have the background of training; our membership committees must be certain that he practices internal medicine only, and that this practice be of high standard, for there are real problems on the part of insuring groups and patients as well, in recognizing and identifying the internist.

Toward this problem real effort must be made in informing the public of what an internist is, and the type of service he is prepared to offer. Although some of this has been done, and more can be done at a State level, the problem is national in scope, and as such, we believe that such public education can best be accomplished at a national level. The California Society believed this so strongly that it loaned its public education moneys, and a considerable sum as well, to be used for the support of the American Society this year.

This necessity for some public education as to what the internist is and what he does was made abundantly clear by a survey conducted by the California Society. This study showed that less than 20 per cent of all persons in a highly urban community had any notion at all as to what internists

are and what they do. The most common and unanimous concept was that the internist was a physician in training.

If no one knows who we are, or what we do, we cannot expect to be favorably received in negotiations, fee schedules, or programs calling for better medical care. The plain facts are that, as individuals, your patients and mine understand the type of care they receive and are quite willing to pay for it; but the great consumer groups do not understand the difference, fear the cost of the internist's specialty in fee schedules, and have no practical way of determining who is and who is not an internist. Such groups and their representatives must be shown that prompt diagnosis, precise and early treatment, are far less costly in money, in health and in suffering than a type of practice geared to the five minute visit, the open shirt collar examination, and the shot. We know this, our own patients know it, and the knowledge must be extended.

Many of our colleagues in other fields likewise have little knowledge of our work. Certainly our State Societies must be informed of the difficult situation now confronting our specialty, lest we continue to be offered as a sacrifice to expedience, premium rates, and the wishes of other medical groups. This has occurred regularly thus far when either State or local societies offer health insurance plans in competition with private carriers or closed panel groups.

The discussion has outlined thus far the need for, first: recognition of our position now and in the future by all internists; then, the necessity of organization of an effective group to deal with these prospects, made up of internists and internists only; and the absolute need for educational effort directed toward the public, the representatives of consumer groups, and our own profession. Other actions shall be taken as soon as the above are well started.

THE NEED FOR ALLIES

Such an organization as the American Society of Internal Medicine will naturally seek allies. Far and away the most effective ally in the summing up might be the American patient. If our patients were all informed that they were about to lose the quality of care they generally enjoy, that when their sons and daughters developed serious illness there would not be available the diagnostic study they now have, nothing could prevent our success. If our patients understood that they are about to be offered a ten

minute examination, diagnostic study by an inexperienced house staff, and a mass of screening x-ray and laboratory procedures instead of sound diagnostic study and exact, prompt treatment, our problems would be ended.

There are other specialty groups in medicine whose problems are similar to ours. In California the pediatrician has endured real financial hardship under current fee schedules, and faces more. Early stirrings of organizations are taking place at a local level.

In a very practical way, the well trained surgical specialist has a community of interest with the internist. Not only does he depend on the internist for consultation and diagnostic help; he is, in an urban community, apt to depend on him for his bread and butter. For such common procedures in surgery as herniotomy, appendectomy, cholecystectomy, and others are most apt to come to him through the internist for surgical consultation, and would surely remain in other hands without the internist. If the internist passes out of the medical picture, so to a greater or lesser degree will the surgical specialist, further lowering the quality of medical care. Such highly practical matters must be brought to the attention of these groups.

I believe that teaching institutions must be made aware of our position, for one of their prime objectives must be the education of men prepared to give sound diagnostic and consultative service.

The American College of Physicians will be a strong ally. This group has thus far chosen to continue its great efforts along scientific, educational standards and honorary pursuits. At the Joint Meeting of the Board of Governors and Regents, Dr. Lewis T. Bullock, chairman of the Interim Committee of the American Society of Internal Medicine, presented the economic problems leading to the foundation of the American Society. This information was well received.

It would not be difficult to define the relationship of the A.C.P. to ASIM. In California practically all the members of the College are members of the California Society of Internal Medicine, and thus of the American Society. The American Society maintains its interest in the economic field; it is as deeply concerned with the standards of admission to its membership as is the College to its own; but

it does not concern itself with the scientific, educational or honorary aspects of the practice of medicine, factors which are the prime concern of the College. Thus, the American Society regards its activities as the economic complement to the American College, directing its efforts so that the scientific and educational standards of the college may be maintained.

OUR ENEMIES

With this discussion of potential sources of strength, there arises the question of whom do we oppose? We oppose those groups and influences who would lessen the quality of medical care in this country by the extinction of the diagnostic study and consultation. We oppose those in organized medicine who fallaciously believe that the internist must be sacrificed in health insurance plans, so that premium costs be competitive.

Yet I do not believe that this Society, or any Society, should attack other units of organized medicine, nor attempt to demean the type of practice of other groups. We have all seen the unfortunate public reaction to the bitter attacks of one group of specialists against the general practice group. Such arguments, fought out in the lay press and periodicals, would seem to cheapen us all, causing a substantial loss of confidence in the profession as a whole, negating any glory or advantage that one specialty seeks to bring on itself.

We must be realistic enough to admit that we may not be able to control to our liking the form American medicine may take, yet we must control the substance thereof. We may not control to our satisfaction the manner in which medical expenses are to be paid, yet we must insure that there be enough to provide for the consultation and the complete history and physical examination, the heart of the practice of internal medicine, and indeed the very foundation of all medical art and science; for if we fall before supermarket medicine afforded by medical technicians and masters of the speed-up, and if medicine for the masses prevails over medicine for all individuals, then American medicine will decline, with us, until the standards are no higher than that which prevails in many other lands.

The knowledge that the problems in New England are those on the Pacific slope, points up the need for our young American Society.

THE ASSAULT ON MEDICINE

ROBERT J. NEEDLES, M.D., *St. Petersburg, Florida*

THE medical profession represents a blend in which tradition, faith and reason have always been given precedence over politics. We doctors are suspicious of those who would meddle with it—on the grounds that it has been carefully wrought, and improves with age and experience.

We had thought, until recently, that we were doing a good job. People are living longer; the death rate is decreasing; and new and even wonderful treatments have been developed. More and better doctors are being graduated. The ill do not always recover, and when they do, recovery is not always complete; but the chances on both fronts are better than they used to be. And while the cost of medical care may seem to have risen somewhat, we are, given the excellence of our present procedures, almost certainly delivering more, not less, service per dollar of receipts.

Our generation chooses to forget the scrap heaps and septic tanks that mark mankind's losses from evil and disastrous experiments in building a leviathan state. Thick blankets of foliage cover the pikestaffs and guillotines, which rust with the bones of silenced human witnesses. The bacteria of time work their way through the clotted offal of fanatic error, and the septic tanks lose their horrid stench. Divine prescience has allowed us to remember pleasure more vividly than agony, violence and terror. Those who are ignorant of historical wisdom would leave us no alternative but to retrace the stumbling, fumbling efforts of those who have preceded us.

The trouble with present-day medical care is not to be found in the quality or numbers or distribution of doctors. The trouble does not lie with the doctors' methods. At the basis of the difficulties there is only one error: namely, the appropriation, by politicians, of a fundamental area of human

emotion, for use as a platform from which they may launch their campaigns for the further subjugation of our citizens.

Wherever the central government has headed toward paternalism medical care has been one of its early targets—and one of the easiest to rationalize. People are suffering, and it is not difficult to generate frenzy where suffering is concerned. But what begins as understandable, if misguided, compassion before long becomes manipulation of public opinion or subservience to public whims.

Doctors are familiar with the sad, omnipresent yearning for complete happiness. It is a matter of daily occurrence in the lives of our patients. We are familiar with grief, loneliness, and the aimless boredom that follow illness or death. We have no material solution for these problems, and we venture to think that no solution is available by Act of Congress.

Continuing excellence in medical care depends upon inequality. Doctors are forced to excel, first, because without such excellence they cannot even be admitted to a medical school. Again, they must excel or they will fail of graduation. In their years as interns, they must excel again, for those selected to remain for further postgraduate training in hospitals are picked from among the better interns. The doctor, should he desire to remain in medical school work, must excel as a teacher or research man. When he gets into practice, he must excel or do without patients.

We may, therefore, draw a curve of excellence on which we may place each member of the profession—among the few at one end, who are outstanding, or among the majority who constitute the ascent and decrease of the curve. Such a curve may of course be drawn for any group or any talent, trait, or quality of men, dogs, ball bearings, or

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hush-puppies. Such variation is the product of divine creation; doctors cannot reverse it, nor may it be reversed by law or decree.

THE TERRIBLE SIMPLIFIERS

Medical care was never a simple matter. And it is less simple today than formerly, when a doctor could carry most of his equipment in his saddlebag. But terrible simplifiers seize upon illness, exploiting false comparisons—for example, medical care with public housing, or with the subsidization of agriculture. They build a creaking edifice of official pity on a foundation of human misery. They promise, in return for your vote, to eliminate human misery.

Medical care leads, finally and unavoidably, to a problem that can be solved by two and only two individuals: namely, the sick person and the physician. Whenever a third party enters the relation, he becomes an object of suspicion and distracts attention from the business in hand. And when that third party is a vast and powerful national government, beginning to act like a mother-in-law about to settle down for a long visit, there is genuine reason for alarm.

For it is a tempting thing, this great pool of voters, no one of whom is happy either with his illness or the size of his medical bill. Few of them—some 200,000 at most—are doctors; and most politicians yield automatically to the temptation to shed tears in trade for the votes of the remainder. The minority, the politicians intimate, is operating in selfish disregard of the needs of the majority. And the solution offered, oddly enough, is new laws and appropriations of money. The demonstrable ineptitude of government operations in general is ignored—in favor of questioning the character and ability of the minority. The majority is encouraged to believe that physicians are heartless mountebanks, and candidates for office just lower than the angels.

The need in question cannot be demonstrated by means of figures: On the contrary, the figures refute the alleged necessity for such interference. Appeal is made, therefore, to sheer emotion, by playing upon the symbols of sickness and death. Medical care is equated with merchandising operations. But merchandise varies greatly in quality, and prices vary with the customer's ability to pay and his selection of quality.

Now, in spite of a ruthless selective process in the education of physicians, which promotes in-

equality among them, those who survive it are pledged to make their performance as equal in quality as humanly possible. They strive, by work and study, to further its excellence, and by deep professional instinct shy away from the idea that the standard of medical care should be lowered to a static equality in order to equalize its cost. Medical care, in a word, has always been based upon the idea of excellence, without specific regard to the cost to the patient.

Moreover, if physicians began to sell medical care like furniture, the resulting dangers would be breathtaking. The furniture salesman does not press the customer to buy the divan he cannot pay for; and presumably the furniture salesman type of physician would not urge any operation or examination beyond the patient's means. As matters now stand, some of the finest medical care available is provided in charity wards of the great teaching hospitals; and every physician in private practice has some patients who pay him no money. In such cases, his is a spiritual compensation, difficult to enter in a ledger.

Doctors, I repeat, do not offer merchandise of graded quality. They offer only one quality—each of them the best of which he is capable. And fees differ from doctor to doctor because no other arrangement would make sense. Standardization of fees, whether by government or by insurance tables, would involve the presupposition that one doctor's services are equal to another's, which would be the case only if all were of the same degree of excellence.

When one buys ordinary insurance, one pays a certain premium, which is based upon actuarial data, and receives in return a guarantee of a certain benefit, payable in dollars. Health insurance cannot be different, because it also must be sold for a certain premium, based upon actuarial data, and must be payable in dollars.

To date most insurance intended to cover the cost of medical care, as distinct from the cost of hospitalization, has been limited to surgical procedures, and for good reason. It is easier, at least on the face of it, to equate one appendectomy to another than to equate one treatment for bursitis to another. It is likewise easy to set a flat fee for a hospital visit, presuming it to be the equal of all other hospital visits. But in general the assumption of equality is an outrageous avoidance of the truth.

Surgical procedures and hospital visits do not

form the bulk of medical practice. The bulk of medical practice is a person-to-person affair, with a physician using every power at his command to alter or eradicate the patient's difficulty, or minimize its impact upon the patient's life; and flat fees that would at the same time be just are out of the question.

To a patient, his doctor is the best—if not in the world, at least the best available. And if the patient did not think so, he would, and should, find another doctor. Doctors need the confidence and cooperation of their patients even more than they need magic bullets. If all the drugs in the world were wiped out tomorrow, the physician would still be a valuable citizen.

Inequality among doctors, then, is compounded by education, by experience, and by the necessity to augment the excellence of the treatment offered, partly, of course, with an eye to reputation. How equalize reputation?

The older we get, and the more we study, the greater becomes our judgment—and our humility. If mediocrity is to be cherished, if human illness is to be approached by the pedestrian equalitarianism of all government project, we have surely lost our case.

Moreover, if you conceive doctors to be equal, then surely it is only accurate to assume that your own children are no better and no worse than other children. If we actually believe in equality, then we must go all the way. Inequality in the promotion of equality would defeat the purposes of equality.

NO DAY OF JUBILEE

Our profound and increasing appreciation of the complexity of life should itself put us on guard against submitting ourselves and our patients to an

ever-increasing stack of inflexible rules. No patient asks for illness, or enjoys it; and no patient enjoys paying for his illness. Perhaps the result of his treatment is unsatisfactory to him. If so, you may be sure that it is not satisfactory to the doctor either.

If your doctors are not as good as you would wish, you may also be assured that they are not as good as they would wish. We doctors have only one unchanging hatred. That hatred, and revulsion, is for the simple-minded, arrogant and loud-mouthed political candidates who for cynical or soft-headed reasons would make of this proud, humble, unequal and imperfect body of men an animated stairway for their ascent to a tax-paid immortality.

"Men," said Thomas Browne, a physician of seventeenth century England, "that look no farther than their outsides, think health an appurtenance unto life, and quarrel with their constitutions for being sick; but I, that have examined the parts of man, and know upon what tender filaments that Fabric hangs, do wonder that we are not always so; . . ." He also said, in answer to those who moan "How long, oh Lord, how long?", that "the answer to this question will only come on that day of Jubilee which will reconcile the unanswerable doubts that torment the wisest understanding, and which has power to make us honest in the dark, and to be vertuous without a witness."

Our peril as a nation, and our individual peril as patients and physicians, is not that physicians will give inadequate care to those who are ill. The true peril is from false teachers who would persuade us that the day of Jubilee, when individuals are "honest in the dark, and vertuous without a witness," may be mass-produced, by vote of the majority, on earth, and no later than tomorrow morning.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Use of Steroids in Eye Diseases

Several malpractice suits have been reported in other states for blindness resulting from the use of drops and ointments containing cortisone and allied steroids. Herpes simplex and dendritic ulcers simulating a conjunctivitis or "pink eye" have been treated with antibiotic preparations incorporating steroids by nonophthalmologists including nurses and first aid assistants.

Steroids are definitely contraindicated in herpes simplex and dendritic ulcers since these drugs promote corneal ulcers, hypopyon (pus in the anterior chamber of the eye), extensive and permanent corneal opacities, perforation and blind phthisical eyes.

Herpes simplex (febrilis cornea) is a superficial epithelial infection of the cornea characterized by the development of minute epithelial opacities and fissures which may be followed by vesiculation and necrosis, the ultimate typical clinical picture being a dendritic ulcer. A dendritic ulcer is so called because the cornea, when stained with Fluorescein will present a "zig-zag" linear shape with branches.

Herpes of the cornea is seen in association with febrile systemic diseases and herpetic lesions elsewhere. The cornea is very frequently involved. It occurs at all ages and very frequently in children. The clinical picture varies enormously but usually there are intensive irritative symptoms with the appearance of a haze of the cornea. There is often corneal anesthesia. Fluorescein applied to the eye will often show a vesicle in herpes simplex or a

group of vesicles assuming the shape of the branch of a tree in dendritic ulcers. Fluorescein, since it can often harbor pyocyanus organism, should be fresh or applied in the form of sterile applicators (*Fluoristrips).

The treatment of choice is yet to be found. Strong tincture of iodine or ether applied with an applicator at an early stage over a wide area has given best results. These should be applied by an ophthalmologist, as slit lamp evaluation is very important. Even in the hands of competent ophthalmologists many of these cases do poorly.

In summary, if a practitioner or pediatrician suspects herpes or dendritic lesions, Aureomycin drops and ointment should be used until more specialized help can be obtained. It is of the greatest importance to avoid all local eye medications incorporating steroids until herpes or a dendritic ulcer can be ruled out as the cause of "pink eye."

The American Society of Internal Medicine

The avowed intention of the newly formed American Society of Internal Medicine to concern itself solely with the recognition and economic defense of the specialty of Internal Medicine may strike some of the more idealistic among us as a trifle self seeking.

That this condemnation may be shortsighted and actually contrary to the ideals of medicine is strong-

*Ophthalmos, Inc., Union City, N. J.

ly suggested by the remarks of Dr. Callaway printed elsewhere in this issue.

The specialty of Internal Medicine is oriented toward the painstaking evaluation of the individual patient in toto. It requires a history and physical examination which is careful, unhurried, intelligent and exhaustive, and it further requires correlation of laboratory x-ray and consultative data which is informed and thoughtful.

This takes time.

The American Society of Internal Medicine has pledged itself to defend that time against the rising pressures which tend to foreshorten it, and in so doing is placing itself in the position of trying to protect, by entirely practical methods, an ideal technique toward which we have all been continuously inspired since our earliest medical school matriculation.

Doctors in Politics

Olan Meeker, Riverside, formerly Chairman of the Society's Committee on National Legislation and now regional member of the Legislative Committee of the American Medical Association, was a featured speaker at the combined Annual Meeting of the New Hampshire and Vermont Medical Societies in September and his remarks have been called a "hard hitting speech on why doctors should take a more active part in local politics."

It was a stimulating presentation and well received. In urging physicians to take their part as citizens he said "they can preserve the individual freedom which they expect as a natural consequence in their own practice," and "unfortunately many members of the house staff and younger practicing physicians have become tongue-tied when it comes to talking or doing anything about politics. Some are afraid that they might antagonize patients and lose a few; others are fearful that stating their ideas on anything outside of medicine will brand them as advertisers."

In looking back into history he observed "It is fortunate that physicians during the early days of this country had a different attitude about civic obligations and politics." This is a great truth. Five physicians signed the Declaration of Independence, one from Connecticut, Oliver Wolcott, and another Lyman Hall, who originated in Connecticut, signed for Georgia. There was once a doctor Governor of our State, John S. Peters 1827-31, President of the

Society at the same time and in fairly recent times two have been in the Congress, William L. Higgins, Second District, 1933-37, who was also President of the Society and Albert E. Austin, Fourth District, 1939-41. Several doctors have served in the General Assembly, the last William H. Coon in 1939. There are many areas of interest and service in public politics where physicians can be more valuable than others because of their special knowledge and training. Such activities are time consuming certainly, and perhaps subject to criticism which physicians might find distasteful but in a government such as ours all have obligations and responsibilities. Political affairs in themselves are not bad, only "politicians" spoil them.

Foreign Students in the United States

Dr. Dean Smiley of the Association of American Medical Colleges, in a recent editorial in *Medical Education* has provided interesting and thought provoking information concerning foreign students studying in the United States with particular reference to students in the medical sciences.

In 1956-1957, 40,666 foreign students came to the United States to study (22,662 as undergraduates, 14,229 as graduates, 3,775 as special or unclassified students) and 6,741 foreign physicians who came to work as interns or residents in our hospitals, this figure almost equals the entire number of physicians graduated by American Medical Schools in one year.

The sources of these migrants are interesting, 31.8 per cent came from the Far East; 22.4 per cent from Latin America; 14.7 per cent from Europe; 13.4 per cent from North America; 12.9 per cent from the Near and Middle East; and about 5 per cent from Africa and Oceania. Countries contributing the most students were, in the following order: Canada, China, Korea, India, Japan, Philippines, Mexico, Iran and Greece.

Dr. Smiley went further to say that if the 6,740 interns and residents are included with the 3,584 undergraduate and graduate students in medical science, medicine tops the list with 10,595 foreign students as compared with the next highest 9,057 for engineering. The Philippine Islands contributed the largest number of foreign physicians training in United States hospitals, 1,332; Canada was next with 576; Mexico 556; Turkey 427; Germany 324; Greece 305; Korea 296; Japan 253; Italy 242; India 203; Iran

183; Cuba 180; and China 153. 1,988 were working as interns; 4,753 were at the resident level, 13.5 per cent of these physicians were women.

Underlying these facts is an implication that these students have come to the United States to extend their education so that they may in due course return to their own countries with new and broader knowledge for service to their people. In so far as medicine is concerned, as viewed here in Connecticut, it does not work out quite that way. Undoubtedly many do return. But, for one reason or another, a large number elect to stay here and make their future in America. This is a development that, in time, may have a significant influence on the future of medicine in this country and requires broad and careful understanding.

Cost of Medical Care

The Washington Report on the Medical Sciences has published excerpts of a featured article in the September issue of the *Monthly Labor Review*. It is an informative discussion of the ups and downs in consumer prices for medical care and hospital services between 1936 and 1956. Using the years 1947-49 as a base, the price index for medical care at close of 1956 was highest of all major items (housing, clothing, etc.), just as it is today. But this article points out that if hospitalization is stripped out of medical care, the price increase for this item between 1936 and 1956 actually is the smallest of all.

In this 20 year period, hospital room rates went up 264.8 per cent, which explains why the medical care index has risen so much. At same time, however, surgeons' fees have gone up only 59.5 per cent, general practitioners' fees 72.8 per cent and dentists' fees 82.1 per cent. This compares with a 220.9 per cent rise for haircuts, 135.0 for shoe repairs and 112.9 for public transportation.

Istanbul — Old and New

From a vantage point high above the city one is afforded a view of the blue Bosphorus extending northward to the Black Sea and furnishing a passage between Europe and Asia for vessels of all types. At the southern end of the Bosphorus the

Sea of Marmara connects with the Mediterranean while on the west affording access to the Sea of Marmara lies the Golden Horn crowded with vast numbers of craft of all kinds and sizes. Scattered through the old part of the city are picturesque mosques with their delicate minarets pointing skyward and summoning the faithful to prayer. This is Istanbul, the gateway to Asia, a city teeming with history extending back many years before Christ. It was here that between two and three hundred physicians from the far corners of the earth gathered at the end of September to discuss their problems, to encourage one another in a common cause, and to emphasize once again the fact that the practice of medicine crosses all political and racial barriers, a fact not to be overlooked in our efforts to gain world peace. The World Medical Association honored the four year old Turkish Medical Association with the selection of this ancient Byzantine city for its eleventh annual congress.

Istanbul is a strange mixture of the old and the new. Buildings in the process of being torn down, streets in all stages of repair, men carrying enormous burdens on their backs as they have done for centuries in that part of the world, and donkeys mingling in the thoroughfares with American built automobiles, with narrow gauge trolleys and modern buses crowded to capacity at every hour of the day, this is a picture not soon forgotten.

It was a pleasure to seek out a native Turkish doctor trained in anesthesiology in Hartford and carrying on his specialty in his native city with credit as well as success. Likewise the head of the American Hospital proved to us that there still are hardy souls to whom a difficult job is a challenge not to be ignored. And we shall not soon forget the "Y" secretary who together with his devoted wife gave us many hours of pleasure.

As one returns to the States one realizes more than ever our blessings and opportunities. To the World Medical Association is due a vast amount of credit for its accomplishments during the first decade of its existence. With the increase in air travel distances no longer offer obstacles in sharing the problems of the doctor in Kurachi, Buenos Aires and Johannesburg with physicians in New York, London and Paris.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

JAMES G. BURCH
Director of Public Relations

JOSEPHINE P. LINDQUIST
Administrative Assistant

160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

CALL

SEMI-ANNUAL MEETING OF HOUSE OF DELEGATES

The 1957 semi-annual meeting of the House of Delegates will be held at the Hotel Statler, Hartford, on Wednesday, December 11 commencing at 4:30 o'clock in the afternoon.

The purposes of this meeting are:

1. Action upon the Society's budget for 1958 as recommended by the Council.
2. Action on such other matters as may be presented in accordance with the By-laws.

W. Bradford Walker, President
Creighton Barker, Executive Secretary

Council Meeting

A regular monthly meeting of the Council was called to order by the Chairman, Dr. Gallivan, at 4:00 in the afternoon on September 26, 1957, at the offices of the Society. There were present in addition to the Chairman, Drs. Walker, Russell, Johnson, Barker, Danaher, Gibson, Feeney, Ogden, Fincke, Clarke, Buckley, Otis, Archambault, Schiavetti, Ottenheimer, Gens, Seigle, Meyers, Dwyer, Starr, Gilman. Absent were Drs. Weld, Ursone, Gardner, Thayer.

Immediately after calling the meeting to order Dr. Gallivan spoke of the recent illness and convalescence of Frank Ursoni, Councilor from Litchfield County, and it was voted that the secretary should send the best wishes for a speedy recovery from the Council to Dr. Ursoni.

RESIGNATIONS

The resignation of Dr. John Donnelly from the Committee on Industrial Health and Dr. Morris Pitcock from the Committee on the State Blood Bank and Committee on Postgraduate Education were accepted with regret.

COMMITTEE APPOINTMENT

It was voted that Allan C. Mermann, Guilford, be appointed a member of the Sub-Committee on School Health of the Committee on Public Health.

INTERIOR PAINTING

It was voted that the Building Management Committee proceed with arrangements for the painting of the walls and woodwork in the offices and other rooms on the ground floor of the Society's building. Decision as to obtaining competitive bids for this work and the source of the funds to be expended to be left to the discretion of the Building Management Committee.

1958 NEW ENGLAND HEALTH INSTITUTE

It was voted that the Society accept the invitation of the Commissioner of Health of the State of Connecticut to be a sponsoring agency for the New England Health Institute that will be held at the University of Connecticut July 18-20, 1958.

"OPHTHALMIA NEONATORUM PROPHYLAXIS"

It was voted to adopt a recommendation from the Committee on Public Health as follows: "That physicians in Connecticut continue to use 1 per cent solution of silver nitrate prophylaxis for the present and await results of the experiment in New York City before further consideration."

ASIAN INFLUENZA FLU INNOCULATION FOR HOSPITAL PERSONNEL

It was voted to approve the Asian influenza prophylaxis inoculation program for personnel of

the United States Veterans' Hospitals in West Haven and Newington.

CONNECTICUT SOCIETY OF AMERICAN BOARD OBSTETRICIANS AND GYNÉCOLOGISTS

It was voted to inform the Connecticut Society of American Board Obstetricians and Gynecologists that it is contrary to the established policy of the Society to have an organization of restricted membership, such as Diplomates of an American specialty board, be designated as an official specialty section of this Society.

FEE FOR FILING CERTIFICATES

It was voted that the Society recommend no change in the status relating to the 25¢ fee allowed physicians for filing birth and death certificates.

ADVISORY COMMITTEE TO STATE WELFARE DEPARTMENT

It was voted that the title, duties and purposes of the present Advisory Committee to the State Welfare Department be changed to read as follows: "Advisory Committee to the State Commissioners of Welfare and Finance and Control to advise and assist them in all matters concerning the medical care and hospitalization of state beneficiaries, and to promote and foster cooperative relations between state employed personnel and all members of the medical profession."

JOINT MEDICAL SOCIETY—INSURANCE INDUSTRY LIAISON

It was voted that no action be taken at the present time on the proposal that the Society appoint a joint medical society-industry liaison group with the Health Insurance Council.

SEMI-ANNUAL DINNER

It was voted to rescind the action taken at the Council meeting on June 20 relating to a dinner on December 11 during the Clinical Congress and that that dinner not be held. A cocktail party for members of the House of Delegates is to be arranged following adjournment of the meeting of the House on December 11.

MURDOCK SCHOLARSHIP AND LOAN FUND

Dr. Otis, chairman, reported in detail concerning developments relating to the Thomas P. Murdock Scholarship and Loan Fund. Particular reference was made to the federal tax aspects of the project and a letter from Mr. Grant Nickerson, of the firm of Wiggin & Dana, New Haven, legal advisors to

the Society. The conclusion that had been reached was the Society should establish a scholarship trust fund that would be separate from the activities and finances of the Society. This was agreed to by the Council. It was finally voted that the Council Committee on the Murdock Scholarship and Loan Fund (Dr. Otis, chairman, Dr. Danaher, Dr. Fincke, Dr. Gibson, Dr. Barker) proceed with the setting up of a scholarship and loan trust fund after thorough consultation with the Society's attorney and a trust company and at an appropriate time appoint the original trustees of the fund.

1958 BUDGET COMMITTEE

It was voted that the Chairman appoint a subcommittee to prepare the 1958 budget of the Society to be submitted to the Council and the House of Delegates for approval. The Chairman appointed: Chairman, the Treasurer Dr. Johnson; the President, Dr. Walker; the Managing Editor of the JOURNAL, Dr. Weld; the Executive Secretary, Dr. Barker; and Dr. Buckley, Councilor from Middlesex County.

SUB-COMMITTEE ON NUTRITION

Nominations for a Subcommittee on Nutrition of the Committee on Public Health had been received from the Committee on Public Health and it was voted that the Chairman of the Council appoint such a committee and instruct it to prepare and submit to the Council for approval protocol, program and aims of the Subcommittee on Nutrition.

ASIAN INFLUENZA IMMUNIZATION

Recommendations had been received from the Committee on Public Health regarding Asian influenza immunization. These recommendations were discussed by the Chairman of the Council who presented substitute recommendations that included all points in the recommendations received from the Committee on Public Health and certain other important aspects of the Asian influenza immunization project.

The recommendations presented by the Chairman of the Council were discussed and unanimously adopted with a vote that copies of them be distributed by mail to all members of the Society at the earliest practical time, and funds sufficient to cover the costs were appropriated.

"Recommendations concerning Asian Influenza Immunization:

"In the interest of public health in the prevention or attenuation of Asian influenza, the Council of the Connecticut State Medical Society recommends that members of the Society in active practice, regardless of the type of practice, make influenza vaccine containing the Asian strain available to their patients.

"The Council also recommends the intradermal administration of such vaccine as a satisfactory alternate method to the subcutaneous administration, in view of the current limited supply of such vaccine and the lesser local and systemic reactions produced by the intradermal method.

"Medical supervision and careful techniques of administration and screening of recipients are essential. Because there are influenza vaccines which do not contain the Asian strain as well as influenza vaccines which do contain the Asian strain, physicians are urged carefully to examine each vial to make certain that it does contain the Asian strain.

"The Council also recommends that all persons contemplating receiving inoculations of influenza vaccine be cautioned that any individual who is allergic to poultry products should refrain from undergoing inoculation until the procedure is approved by that individual's personal physician."

GUIDE TO RELATIONSHIPS BETWEEN MEDICAL SOCIETIES AND HEALTH AGENCIES

The suggested Guide to Relationships between Medical Societies and Voluntary Health Agencies prepared by a special committee of the American Medical Association had been reviewed by the Committee on Public Health and that committee recommended that the Society approve the suggested guide as was presented with the deletion of paragraph numbered 1 at the bottom of page four—"Arrange liaison by making available medical society representatives on the governing body of the Voluntary Health Agency." The Council adopted this recommendation.

DR. CLIFFORD TO CONFERENCE ON PHYSICIANS AND SCHOOLS

It was voted that Dr. Martha L. Clifford be the representative of the Society at the National Conference on Physicians and Schools to be given by

the American Medical Association at Highland Park, Illinois, October 30 to November 2.

MEDICARE PAYMENTS TO PATHOLOGISTS

The resolution of the Connecticut Society of Pathologists relative to MEDICARE payments to pathologists had been referred to the Committee on Hospitals for review and recommendation and that committee recommended "that in hospitals where pathologists are engaged on a fee for service basis that the same method of payment shall be negotiated with MEDICARE. In hospitals where the pathologists are engaged on a full time salary basis, it is recommended that the status quo be maintained until a decision on this matter has been rendered by the AMA." The Council voted to adopt this recommendation. This is now the method of payment followed by MEDICARE.

HOSPITAL CARE OF MATERNITY PATIENTS

The Sections on Medical Services and Policies as prepared by the Subcommittee on Minimum Standards of Hospital Care of Maternity Patients of the Committee to Study Maternal Mortality and Morbidity had been referred to the Committee on Hospitals for review and approval. Objections to certain parts of the recommendations were raised by the committee and they have been returned to the Subcommittee on Minimum Standards of Hospital Care for further consideration.

STUDENT MEMBERS

Two student members were elected. Irving M. Polayes, New Haven, Albany Medical College—1959, Pre-Med: Duke University, Parent: Abraham Polayes. Herbert Lessow, Hartford, Harvard Medical School—1959, Pre-Med: Wesleyan University, Parent: Jack Lessow.

NEXT MEETING

It was voted that the next meeting of the Council will be held on October 31.

1958 ANNUAL MEETING

It was reported that the 166th Annual Meeting of the Society will be held at the Stratford High School, Stratford, April 30, May 1 and 2, 1958.

The meeting adjourned at 6:15 P. M.

THE HISTORIAN'S NOTE BOOK

WISCONSIN PLANS MEDICAL MUSEUM

THE State Medical Society of Wisconsin has disclosed architect plans for the Medical Museum of Wisconsin to depict progress made by successive generations of Wisconsin physicians.

The museum will be constructed at Prairie du Chien, the site of the Fort Crawford Military Hospital, constructed in the late Eighteen Twenties.

The society has started a campaign to raise \$344,000 for the museum. It is hoped that it will be open to the public in two years.

Plans call for the restoration or construction of four units covering two city blocks. The existing military hospital will be renovated. New buildings will include a museum 120 by 40 feet; an administration structure sixty by forty feet; a pavilion and a parking area for nearly 120 automobiles. All will overlook the Mississippi River.

It was at this hospital where Dr. William Beaumont, more than 125 years ago, completed his basic studies in the physiology of digestion. His findings opened a new field of practice in internal medicine. The north room will be restored as his study laboratory and bedroom. The center room will depict the hospital ward of Dr. Beaumont's era and the south room will have displays of appropriate memorabilia and medical equipment of that day.

Dioramas of military life, with its epidemics and emergencies, will portray the importance of the military physician surgeon laboring under most primitive conditions.

The State Historical Society will operate the museum working in cooperation with the State Medical Society's section on medical history.

The museum proper will tell the story of medicine and its auxiliary services, such as pharmacology, medical and surgical instruments and supplies. The contributions of Wisconsin physicians will be featured. Exhibits will be changed periodically. The museum will include a projection room with appropriate films available at all times merely by pressing a button. In the same area will be a complete physician's office as of the Eighteen Seventies.

The administration building, east of the museum,

will house the curator's workshop, an office, waiting and rest rooms. A driveway and loadings dock are provided at the rear with a covered breezeway connecting the two buildings.

The pavilion will serve as a picnic area, with a fireplace and benches. It also will be a protection area during inclement weather and a waiting place when visitors are too numerous for a normal flow through the various buildings.

Discuss Mutual Problems

Members of the AMA Board of Trustees met recently with a number of insurance company presidents and medical directors to discuss mutual problems and try to develop a better working relationship between the medical profession and the insurance industry.

The informal meeting, sponsored by the Health Insurance Council, covered a variety of subjects, including such questions as:

What means are available to medicine and insurance for combating inflation of health care costs, and what has been the effect of insurance on health care charges?

How can communication and cooperation between medicine and insurance, especially at the local level, be made more effective?

For what probable changes in the practice of medicine should insurers be preparing so as to provide sound voluntary coverage of future costs?

How can medicine and insurance cooperate more effectively to stimulate a more enlightened public attitude toward the private practice of medicine and voluntary health insurance?

It was the consensus of those who attended the meeting that the continued effectiveness of voluntary health insurance requires good communications between the insurance industry and the medical profession, and mutual understanding of each other's problems and methods of operation. Accordingly, it was agreed that similar meetings be planned at national, state, and local levels.

Special Article

JOINT BLOOD COUNCIL LAUNCHES TRANSFUSION SERVICES SURVEY

MORE than 5,200 hospitals, blood banks and other blood transfusion services are now receiving by mail a questionnaire from the Joint Blood Council, representing a major effort to provide a sort of mariner's guide to the vast and almost uncharted sea of blood banking and related activities in the United States and territories.

Recipients of the questionnaire are urged to fill it out and return it to the Joint Blood Council because of what this Survey of Blood Transfusion Services will mean to them, individually, and to the nation as a whole. They are reminded that as they sow, so shall they reap in terms of the new light it will shed on the often confused and confusing blood banking picture.

President Eisenhower has hailed the objectives of the Joint Blood Council and its member institutions in seeking to coordinate the nation's blood banking facilities, practices and terminology. On January 27, 1956, he wrote to Dr. Leonard W. Larson, Council president, praising the American Association of Blood Banks, the American Hospital Association, the American Medical Association, The American National Red Cross and the American Association of Clinical Pathologists for their combined efforts in making this "important contribution to the welfare of our country."

With success depending so greatly on the number and quality of replies to its questionnaire, the Joint Blood Council points out that it is part of what President Eisenhower, in his letter to Dr. Larson, called "a humanitarian effort in keeping with the American tradition."

The questionnaire represents a second phase of the Joint Blood Council's efforts to bring the blood transfusion picture into proper focus. The first phase was a postal card survey of blood usage during the calendar year 1956. That produced some eye-opening information on the sources of blood in the United States. It also furnished the first reliable estimate in six years of how much blood is being transfused in the nation.

The Council itself grew out of the need for closer cooperation among facilities which handle blood and between the independent blood banks

and the regional and national blood banking systems. Its survey of blood transfusion services is another step in that direction. The Council's preliminary research has firmed its conviction that blood transfusion services in this country are operating under handicaps that cry out for remedy; likewise the Council's realization that remedies can be applied properly only with accurate diagnosis. The current questionnaire will help clarify the symptoms that will make diagnosis and remedy possible.

In seeking a fuller understanding of blood's problems, the Council shares with the medical profession as a whole the sad recognition of such deficiencies as that wherein no completely safe or entirely satisfactory system exists for exchanging blood or blood credits on a nationwide scale. Moreover, those involved in blood transfusion services are hampered by terminology and nomenclature. For example, there is no precise definition of the frequently used term "unit" of blood. In some instances a "unit" is 480 cc.'s, in others 250 cc.'s, and there are further variations.

The term "blood bank" comes readily to many tongues, but what does it mean? Is it simply a place where whole blood is stored under refrigeration, or do such factors as recruitment of blood donors, processing and distribution enter in? And if so, to what extent?

With such questions begging for answers, no wonder that Joint Blood Council's file of correspondence looking forward to results of the survey of blood transfusion services is studied with such expressions of interest as these on the part of member institutions:

"The American Hospital Association is aware of the importance of the nationwide survey and offers to assist and cooperate in every possible way."

"The Board of Trustees (of the American Medical Association) authorized me to offer the Joint Blood Council all the facilities and resources of AMA which may be of assistance in your project.

"The American Association of Blood Banks has always been eager to learn more about blood banking facilities."

The president of the American National Red Cross said, "I can assure you that the American Red Cross is interested." His letter states further that staff assistance may be called on for any assistance necessary.

Under the threat of atomic attack, the federal government is vitally concerned with blood supply since blood would be a first requirement of nuclear casualties. And Office of Defense Mobilization outline of the new national blood program emphasizes the need for coordination in line with Joint Blood Council aims. Civil Defense headquarters in Washington has asked for guidelines regarding the nation's capacity to supply whole blood in emergency. The Council's schedule of questions will help supply those guidelines. Among the questions it asks concerning the nation's blood transfusion services are these:

Are they capable of rapid expansion in time of emergency?

Where are they located?

How are they organized and operated?

What areas do they serve?

What is their annual volume of business?

How do they relate to allied services, such as tissue banks?

With the promise of getting answers to such questions, federal agencies concerned with hospitals eagerly anticipate the results of the Joint Blood Council's Survey of Blood Transfusion Services. Veterans Administration officials have offered to assume responsibility for distributing and collecting the questionnaire at hospitals within their jurisdiction.

At the industry level, pharmaceutical and hospital supply firms will profit by the blood survey. The facts it assembles will enable them to plan with more assurance in producing blood derivatives, blood bank supplies and equipment, laboratory apparatus and research instruments.

Thus the Joint Blood Council emphasizes that the sooner its questionnaire is filled out, analyzed and interpreted, the sooner will there be a general fund of information necessary to the proper development of a national blood program—a well known and respected transfusion service to the people of the United States through the medical profession.

AMA To Meet December 3-6 in Philadelphia

The American Medical Association's 111th clinical meeting, set for December 3-6 in Philadelphia, will be aimed at helping the general practitioner "catch up" on the latest medical advances.

Approximately 4,000 physicians are expected to attend the meeting, which is intended to provide the family doctor with information about the latest special techniques, treatments, medicines, and equipment.

The AMA council on scientific assembly and the general committee, headed by Dr. Gilson Colby Engel of Philadelphia, have nearly completed plans for the scientific meeting.

Center of activities will be Convention Hall where scientific and technical exhibits, color television, motion pictures, and scientific lectures will be presented. There will be 120 scientific exhibits prepared by physicians and 160 technical exhibits prepared by pharmaceutical houses, equipment manufacturers, and medical publishers.

Approximately 200 physicians will participate in lecture meetings, symposiums, and panel discussions on such subjects as cardiovascular disease, cancer, emotional problems of menopause, hypertension, diabetes, arthritis, and injuries.

A special feature of the meeting will be a trans-Atlantic conference between physicians in Philadelphia and London. The conference on advances in chemotherapy of cancer will be held via telephone at 3 p. m. (EST) Wednesday, December 4.

Closed circuit television clinics, featuring Philadelphia physicians, will emanate from Lankenau Hospital. A medical motion picture program is also being prepared.

Headquarters will be the Bellevue-Stratford Hotel, where the AMA House of Delegates, the association's policy-making body; the Board of Trustees, and various councils and committees will meet.

The first action of the House of Delegates when it convenes Tuesday, December 3, will be to name the General Practitioner of the Year. This award is given annually to an outstanding American family doctor.

DS . . .

*nal is indebted to Mr. George Bugbee, president of
Foundation, for this discussion of community needs*

be- That act, in addition to providing federal funds to
-by match local funds for hospital construction, requires
part- that each state plans the number of hospitals it needs
rem. and where they should be constructed. Each state
unit then approves federal grants for part of the cost of
a to the hospitals it considers most necessary and most
me? likely to provide adequate service.

ysi- The finest contribution made by this program is
rth- that it draws the attention of states to the need for
community, state and regional planning of hospital
om- facilities. As a result it adds to the marked progress
pital in recent years in the distribution of hospitals nation-
reat- ally. Whereas in 1940, 14 states had fewer than three
nity, general hospital beds per 1,000 population, there
hos- are no states below that level today—a fact which
om- illustrates the real value of bed-population ratios as
om- measures of progress.

medi- This does not mean that our bed distribution
problems are virtually solved. There are still many
onal American communities with too few hospital beds
half and some without hospital facilities. Moreover, even
while communities matching the national bed population
lities ratio of 4.2 beds per 1,000 are not exempt from the
may continual self evaluation of bed needs.

small If anything, this difficult self evaluation is be-
hos- coming increasingly complex. With a growing
rved population; a larger group of people in the upper
nity age grades who require more days of hospital care
beds. per year; an increased use of hospitals by physicians

INTRAVENOUS Compatible with common IV fluids. Stable for 24 hours in solution at room temperature. Average IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.

ACHROMYCIN

THERAPEUTIC BLOOD LEVELS ACHIEVED

Many physicians advantageously use the parenteral forms of ACHROMYCIN in establishing immediate, effective antibiotic concentrations. With ACHROMYCIN you can expect prompt

INTRAMUSCULAR Used to start a patient on his regimen immediately, or for patients unable to take oral medication. Convenient, easy-to-use, ideally suited for administration in office or patient's home. Supplied in single dose vials of 100 mg., (no refrigeration required).

ACHROMYCIN



Hydrochloride
Tetracycline HCl Lederle

IN MINUTES -- SUSTAINED FOR HOURS

control, with minimal side effects, over a wide variety of infections - reasons why ACHROMYCIN is one of today's foremost antibiotics.

WATERBURY MEDICAL ASSOCIATION CELEBRATES 100TH BIRTHDAY



Dr. William Finkelstein, right, president of the Waterbury Medical Association and Dr. Rudolph A. Damiani, member of the association's Centennial Committee, explain the network of emergency medical call plans depicted by this exhibit to Cornelius F. Maloney, managing editor of the *Waterbury Republican*, who points out the location of the Waterbury emergency service. The exhibit was one of many displayed at Castle Memorial Hall, the association's headquarters, during a public presentation, October 23-25, which marked the third phase of a year-long observation by physicians and the people of "One Hundred Years of Medicine in Waterbury."

The Waterbury Medical Association opened its Castle Memorial Hall October 23-25 to residents of the community who came to view exhibits and displays portraying medical progress as the third phase of the year-long celebration of the association's one hundredth birthday.

The displays featured old surgical instruments, books, records and ancient articles of medical equipment. Also displayed were paintings of early medical scenes and portraits of early Waterbury physicians, collections of surgical knives, nurses' uniforms, and exhibits pertaining to community services.

In a section entitled "Triumphs of Modern Medicine" the development of insulin, antibiotics and other drugs was depicted. A number of other graphic exhibits displayed advances in research by pharmaceutical companies.

A continuous showing of motion pictures in the lecture room on the first floor of the building was featured during the three days of the event and public lectures on early medicine in Connecticut were also presented.

The observation of the Centennial began last February 5, exactly 100 years after the incorporation of the association. At that time Dr. Edward H. Kirschbaum, Waterbury, presented a history of the association's activities and an oration, "The Simplicity to Wonder," was presented by Dr. John H. Krantz, Professor of Pharmacology at the University of Maryland College of Medicine.

Dr. Paul Dudley White, Boston, was the featured speaker at the second phase of the observance on April 24. He presented a public lecture, "Cardiac Disease—100 Years Ago and Now" which was enthusiastically received by a large number of citizens of the community.

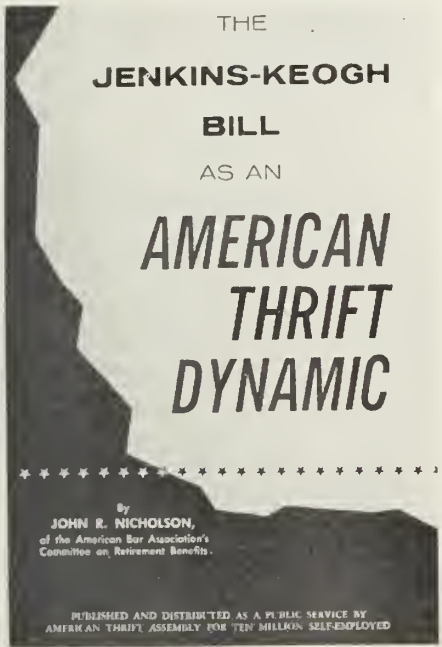
The centennial program was conceived as a service to the residents of Waterbury and the planning committee was headed by Dr. Orpheus J. Bizzozero and Dr. Joseph F. Burke as co-chairmen. Physicians who served on the committee were William P. Arnold, Jr., Rudolph A. Damiani, Salvatore F. DiLorenzo, Jacob Ganther, Edward H. Kirschbaum, Henry Merriman, James H. Root, and William Finkelstein, association president and member ex-officio.

PUBLIC RELATIONS
COMMITTEE ON PUBLIC RELATIONS

Harry C. Knight, Middletown
Chairman
Harold A. Bergendahl, Norwich
James C. Canniff, Torrington

E. Tremain Bradley, South Norwalk
Amos E. Friend, Manchester
John L. Phiffer, Rockville

Ralph L. Gilman, Storrs
James H. Root, Jr., Waterbury
William A. Richardson, Noroton
Associate Member



American Thrift Assembly Announces First Publication on Jenkins-Keogh Bill

The American Thrift Assembly organized early this year to advance retirement programs for self-employed persons equal to the tax-sheltered plans available to those working for others, recently announced its first information booklet.

Written by John R. Nicholson, of the American Bar Association's Committee on Retirement Benefits, the eight by five inch booklet, cover reproduced above, contains twelve pages of information concerning provisions of the proposed tax deferment legislation for self-employed individuals in the professions, in business and in agriculture.

The publication lists 22 national organizations, including the American Medical Association and the American Bar Association, whose leaders will participate in the program of the Thrift Assembly to provide information for their self-

employed members. Copies of the booklet can be obtained by writing to the offices of the Connecticut State Medical Society, 160 St. Ronan Street, New Haven 11, Connecticut.

Health Careers Program Being Planned for Students

A comprehensive health careers program for high school students is being developed by the Society's Public Relations Committee and the Recruitment Committee of the Woman's Auxiliary to the Society.

The program will be statewide in scope, with local committees of the Auxiliary in charge of arrangements in cooperation with faculty members of city and regional high schools. Mrs. John A. Bucciarelli of New Canaan is chairman of the Recruitment Committee of the Auxiliary.

As presently proposed, the program would include films depicting careers in medicine, nursing, dentistry, pharmacy, medical technology, medical secretarial occupations, medical social work, occupational therapy, physical therapy, nutrition, health education, vocational rehabilitation, safety engineering, public health administration, hospital administration, and other careers.

Following film showings, physicians, nurses, dentists, pharmacists, and careerists in medical technology and other health fields will be asked to participate in speaking programs and interviews with students in cooperation with vocational counselors at the high schools.

"Whitehall 4-1500" New AMA Film for Community Groups

"Whitehall 4-1500," a new film portraying the activities of medical associations, will be available for community showing early in December.

Produced by the AMA, the film is narrated by John Cameron Swayze, radio and television com-

mentator, and demonstrates the services of the AMA through physicians and medical associations.

"What doctors do as a group is sometimes more important than what they do individually. . . . No wonder, then, that the switchboard at Whitehall 4-1500 (the American Medical Association) is a busy place. Yet wherever the betterment of public health is concerned, your family doctor, through his organization has answered that call."

"Whitehall 4-1500 tells how doctors as a group work to bring better medical care to all Americans. It's the story of your society and its members in action, told through dramatic case histories and testimonials."

U. S. to Observe Medical Education Week in April

The third annual Medical Education Week, nationwide tribute to the progress of American medical schools, will be promoted during the fourth week in April by United States medical schools and the medical profession.

April 20-26 will be devoted to an all-out effort to create a greater understanding among the public of of both the achievements and the problems of medical schools. Each of the sponsoring organizations—the American Medical Association, the Student American Medical Association, the Woman's Auxiliary to the AMA, the Association of American Medical Colleges, the American Medical Education Foundation, and the National Fund for Medical Education—is asking its members to reserve this week for community and statewide salutes to area medical schools.

Local and state programs will be reinforced by national publicity through network television and radio, newspaper syndicates, and magazines. In addition, the sponsors will send promotional aids to their state and county officers to help in local observances.

During the 1957 Medical Education Week, medical societies in 32 states and woman's auxiliaries in 42 states planned various activities, and their past successes are expected to lead to an even more widespread acknowledgment of the achievements of medical schools in 1958.

THE DOCTOR'S OFFICE

Colby S. Stearns, M.D. announces the removal of his offices for the practice of diagnostic radiology to 758 Main Street, East Hartford.

Edward B. Swain, M.D. announces the opening of an office for the practice of psychiatry at 7 South Main Street, West Hartford.

Richard Wexler, M.D. announces the opening of an office for the practice of ophthalmology at 166 East Avenue, Norwalk.

State Society Meetings Held in October

- 1—Litchfield County Medical Association
- 2—Connecticut Health League Board of Directors
Fairfield County Medical Association
- 3—New London County Medical Association
New Haven County Women's Auxiliary Board
- 4—1958 Budget Conference
- 7—Committee on Eye Care
- 8—State Committee on Professional Relations Hearing
- 9—Committee on Maternal Morbidity and Mortality
Casualty Planning Committee
Committee on Industrial Health, Executive members
- 10—Middlesex County Medical Association
- 11—Conference on Cooperation with the Yale School of Medicine
- 16—Committee on Perinatal Mortality
Committee on Accident Prevention
- 17—Committee on Public Health
Windham County Medical Association
- 23—Committee on Hospitals
Committee on Industrial Health
Connecticut Cancer Society, Annual Meeting
- 24—New Haven County Medical Association
- 31—Council

OBITUARIES

Thomas L. Thomson, M.D.

1872 - 1957

Dr. Thomas L. Thomson died on April 18, 1957. He was born in Bovina, New York, on June 20, 1872, the son of William Blythe and Janet MacEachron Thomson. He attended Geneva Preparatory School and College in Geneva, Pennsylvania, for six years and graduated from Princeton University with a B.A. degree, and from Hahnemann Medical School in Philadelphia. Prior to taking up the study of medicine he taught astronomy and mathematics for two years at Anny College in Iowa. Following his graduation from medical school he interned for one year and then came to Torrington to engage in general practice. In the ensuing years he soon became recognized both by the laity and his professional colleagues for his outstanding ability as an obstetrician which led him eventually, in the early nineteen thirties, to devote his time exclusively to this specialty. He served as chief of the Obstetrical Service at the Charlotte Hungerford Hospital for a period of twenty-five years, until his retirement from active practice. He was on the staff of the Charlotte Hungerford Hospital since its opening in 1915.

Dr. Thomson truly possessed all the qualities and attributes of the ideal physician and citizen. He was kind, patient and tolerant at all times, despite the tremendous demands which his work often imposed upon him. He was admired and highly respected among his townspeople and as a tribute of their love and esteem he was given a testimonial dinner in 1947 marking close to a half century of medical practice.

Dr. Thomson was a past president of the Torrington and Litchfield County Medical Societies and a former vice president of the Connecticut State Medical Society. He was a vestryman of the Trinity Episcopal Church and a member of the Torrington Club and the Torrington Country Club.

Surviving besides his wife, the former Eloise Morton, whom he married in 1903, are two daughters, Mrs. Henry Ellis, Jr. and Mrs. George N. Armstrong, and six grandchildren.

We, his fellow practitioners, who knew him shall ever remember his amiable character, his integrity, his professional ability, his modest and unassuming ways, and the many pleasant and memorable associations with him. His passing has left a void in the hearts of all who knew him.

Michael E. Giobbe, M.D.

Anthony William Branon, M.D.

1887 - 1957



On July 3, 1957 Dr. Anthony William Branon died at the age of 70 years in his home at Fenwood, a Saybrook section. His death was unexpected, although his health had been failing for the past few months.

Dr. Branon was born in Fairfield, Vermont in 1887, and received his early education in the local institutions and the University of Vermont. He was graduated from the Jefferson Medical College in 1913 and interned at the Hartford Hospital in 1914-15. He was one of the early volunteers for medical service in the first World War, and was discharged as a first lieutenant early in 1918, due to a sinus involvement which had started early in his life. He returned to Hartford and attained the respect and

appreciation of his confreres and patients. In 1926 he became an assistant surgeon at the Hartford Hospital and served on the surgical service until 1956, when he was appointed to the honorary staff.

Dr. Branon was one of the first surgeons appointed to the present McCook Hospital and served this institution in a very zealous and serious manner for many years.

In addition to his membership in the local and state societies, he was also a member of the American College of Surgeons.

In 1945 Dr. Branon moved to Old Saybrook. At that time he had started developing the tract known as Fenwood, and soon become so engaged in this new venture that he forsook the practice of medicine. His undertaking in real estate became most successful and now stands as a monument to his foresight.

He leaves his wife, Gladys Reid Branon, of Old Saybrook, a daughter, Elizabeth Lambert of Boston, Massachusetts, and two sons, William and David of Saybrook.

Bill had a great trait in forming intimate friends through his generous and considerate nature. His wit was a distinct personal characteristic which endeared him to one and all.

May his soul rest in peace.

William J. Fay, M.D.

James J. Donohue, M.D.

1872 - 1957

On Friday, September 27, 1957, Dr. James J. Donohue of Norwich passed away. He was a native of Norwich and resided there all his life. He was born December 3, 1872, son of Thomas and Ellen Donohue. Reared on his father's farm, his formal education was acquired in local schools and the Norwich Free Academy. He was graduated from the University of Maryland, College of Physicians and Surgeons in 1896 and came back to practice medicine in Norwich. He served as chief of the surgical staff for the W. W. Backus Hospital and as consulting surgeon to the Norwich State Hospital. He was a fellow of the American College of Surgeons and of the International College of Surgeons.

He also served as the second district's Workmen's Compensation Commissioner for a total of twenty

three years. He took an active part in civic and political affairs and made known his opinion in no uncertain manner.

One of his great loves was for the outdoors where he liked to fish and hunt, and at the time of his death was the president of the Westbrook Fishing Club.

He is survived by his widow, Mrs. Sarah Donohue, and a son, Rev. James C. Donohue.

William V. Wener, M.D.

Daniel Joseph Sabia, M.D.

1909 - 1957



Dr. Daniel Joseph Sabia, of Stamford, Connecticut, died at the Stamford Hospital August 6, 1957 after an illness of one year.

Dr. Sabia was born in New York City on August 7, 1909. He received his early education in Stamford, where he lived for 45 years. He attended Syracuse University and the University of Louisville, where he graduated in 1932. He received the degree of Doctor of Medicine from Marquette University Medical School in 1936. After interning at St. Joseph's Hospital in Providence, Rhode Island, and at St. Paul, Minnesota, he began the general practice of medicine in Stamford in 1938. He left his practice in 1941 to enlist in the Army Medical Corps, in which he served for five years, being discharged with the rank of captain. Following his discharge he was associated with the Veteran's Administration

for a short period before resuming his medical practice in Stamford in 1946.

At the time of his death Dr. Sabia was on the medical staffs of Stamford Hospital and of St. Joseph's Hospital in Stamford. He was a member of the Stamford Medical Society, the Fairfield County and State Medical Societies, of the American Medical Association, and of the Academy of General Practice.

Aside from his interest in golf, Dr. Sabia's life was devoted to his medical work. In his quiet and unassuming manner, he served his patients conscientiously and well. It can truly be said of him that few in his profession are criticized less.

Dr. Sabia is survived by his father, two sisters and six brothers, and by his son, Donald.

Frank H. D'Andrea, M.D.

Irving Dichter, M.D.
1906 - 1957



On August 29, 1957, shortly after an obstetrical delivery, Irving Dichter died. He died as he lived, full of the joy of the practice of medicine, but all too young at 51.

We in Stamford had learned to know and love Irving Dichter. For he was no ordinary man! By any criterion he would stand out from the crowd.

He was first and foremost a physician—a true and dedicated physician—a counsellor and helper in time of need, devoted to his patients and their families. He was full of life, for he was a “complete man.” He served on many hospital committees at the Stamford and St. Joseph's Hospitals, on whose surgical staffs he was a member. He was a member of the Medical Board of the Stamford Hospital. He was an Associate of the International College of Surgeons, a member of Phi Sigma Delta at Columbia and of Phi Delta Epsilon at Jefferson. His civic interests were many. He was responsible for the Stamford Chapter of the Aid to Retarded Children, and served on the Medical Advisory Committee of the Visiting Nurses Association. He was a member of the Stamford Chapter of the American Red Cross and the Stamford Heart Association, as well as the County and State Medical Societies and the American Medical Association. He was a member of the American Academy of General Practice. He helped establish the Chamber Music Associates at the Ferguson Library. He loved music and was the owner of one of the largest private collections of classical records. He was a connoisseur of violins, and the possessor of several irreplaceable ones. He played beautifully. He was instrumental in developing a music scholarship fund in the name of his former teacher, and this fund has now been enlarged and will bear Irving Dichter's name as well. He was an artist of note, and in 1948 had a one-man show at the Stamford Museum presenting sixty paintings, many of which were done while he served overseas with the Army.

He is survived by his wife, the former Rosalind Pinto, a daughter, Mrs. Ellen Parmacek of Chicago, and a son, Stephen. His father, Dr. Charles Dichter is Stamford's oldest practicing physician. He leaves also a brother, Attorney Melvin Dichter, and a sister, Mrs. Philip Diamant of Stamford.

So Irving Dichter's name will be perpetuated in a Music Scholarship Fund, in a large collection of books given by the surgical staff members to the hospitals he served so well, and in a plaque in Temple Beth-El, but more importantly his name will be forever in the hearts and minds of his patients and friends and colleagues.

Leo Hymovich, M.D.

NEWS FROM WASHINGTON

Ruling Puts New Slant on Corporate Practice

Controversy over practice of medicine by hospitals is given a fresh twist by an Internal Revenue Service ruling. Advice had been requested as to whether an anesthetist who serves two hospitals—one on a fee for service basis and the other for a fixed monthly payment—is an employee or an independent contractor, for government tax purposes. In the case at issue, the anesthetist was not a doctor of medicine.

IRS held that his services to the hospitals are as an independent contractor, rather than an employee, because working conditions are not those of the usual employer-employee relationship. Further, the ruling makes it implicit that the services rendered are not medical, since the anesthetist is not a physician and therefore his earnings are regarded as the product of a trade, rather than a profession, for tax purposes.

In a companion ruling, however, it was held that an anesthetist who works exclusively for one dental surgeon on a full-time basis is an employee of that dentist even though her sole remuneration consists of charges listed separately on the dentist's billheads. Note: Both rulings appear in Internal Revenue Bulletin for August 26, purchasable (20¢) from Government Printing Office, Washington 25, D. C., or WRMS.

Hearing Scheduled for Next Year on Jenkins-Keogh Plan

Chairman Jere Cooper (D-Kentucky) of the House Ways and Means Committee, which steadfastly has refused to consider the Jenkins-Keogh bills this year, has announced general taxation hearings to start next January 7, when this legislation will be among the subjects taken up.

The Jenkins-Keogh plan, strong supported by the AMA, would allow self-employed persons to set aside a portion of their income in pension plans and defer payment of income tax on it until it is received back in the form of pensions. Corporations now may do this for their employees. The Ameri-

can Thrift Assembly, headquartered in Washington, has carried on the fight for the legislation this year.

Psychiatrists' Dispute Over Tax Gains Impetus

Another physician has filed petition with U. S. Tax Court, contesting Internal Revenue Service ruling that psychiatrists may not deduct costs of psychoanalysis—performed on themselves—as a business expense. This makes the sixth case to be carried to the court. Fight is being led by American Psychoanalytic Association. It is represented by one of the country's best tax law firms—Stevenson, Paul, Rifkind, Wharton & Garrison. Internal Revenue holds that when a psychiatrist, who is receiving training in psychoanalysis, himself undergoes analysis the cost of same is a personal expense rather than an ordinary expense incidental to the taxpayer's professional practice. And so, says IRS, it may not be deducted for tax purposes.

Opposite argument is that cost of psychoanalysis is properly deductible both as a consultative item of expense and as an implement of therapy necessary to the doctor's well being; in short, as a business and medical expense. IRS rejects these arguments, hence these petitions to U. S. Tax Court. And it is reported that a great many more similar appeals are in preparation throughout the country.

IRS contends that when a psychiatrist becomes qualified as an analyst—and he must undergo analysis to achieve such accreditation—he attains a higher professional level and so cost of analysis is not "ordinary." Opposite argument: Psychoanalysis is no separate medical specialty and its advantages lie in the better psychiatric care which it makes possible, and not in increased earnings on the part of doctor.

Auto Safety Belts Receive Wide Indorsement at Hearing

With one exception, witnesses appearing before the Traffic Safety Subcommittee of the House Interstate and Foreign Commerce Committee testified they favor automobile safety belts. Indorsing the device were spokesmen for industry, Air Force,

CONFIRMED THERAPEUTIC UTILITY



Pro-Banthine® “proved almost invariably effective in the relief of ulcer pain,

*in depressing gastric secretory volume and in inhibiting gastrointestinal motility.”**

“Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies.”*

Among the many clinical indications for Pro-Banthine (brand of propantheline bromide), peptic ulcer is primary. During treatment, Pro-Banthine has been shown repeatedly to be a most valuable agent when used in conjunction with diet, antacids and essential psychotherapy.

Therapeutic utility and effectiveness

of Pro-Banthine in the treatment of peptic ulcer are repeatedly referred to in the recent medical literature.

Pro-Banthine Dosage

The average adult oral dosage of Pro-Banthine is one tablet (15 mg.) with meals and two tablets at bedtime.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastrosopic Studies. Report of 60 Cases, Am. J. M. Sc. 232:156 (Aug.) 1956.

SEARLE

Public Health Service and American College of Surgeons

The sole dissenter was Andrew J. White, director of a private motor vehicle research organization, who contends that a "massive plan of action" is needed to bring the entire structure of the car in line with recognized safety principles. He said: "If it is possible to select the type of accident you are going to be involved in, wear a seat belt; if not, do not wear one as it may be the cause of death or serious injury."

The industry representatives—from Ford, General Motors, Chrysler and American Motors—readily agreed the belts have obvious advantages, when properly designed, installed and worn. The Ford witness said the belts could reduce the fatalities by 50 per cent. However, none of the industry witnesses would agree with committee members that perhaps the belts should be made compulsory equipment. They said a public educational campaign was in order, but that it shouldn't be industry's role to lead the campaign. The committee is considering a bill that would require safety belts to meet certain standards set by the government.

Dr. R. Arnold Griswold, representing the College of Surgeons, indorsed the belts, "because it is best to make a compromise between maximum protection and optimum protection," in the light of slow public acceptance. He said the belt may make the most impressive record in the greater number of nonfatal injuries, where lesser force is apt to be involved.

Col. John Stapp of the Air Force's aeromedical laboratory, where research is being done on safety belts in ground vehicles, said auto accidents injure more AF personnel than any other type of accidents, and kill more than any accidents except airplane crashes. Col. Stapp personally advocated the belts, and believes they may become required equipment on AF autos and trucks.

The House Interstate subcommittee on Traffic Safety has come out in favor of safety belts for the motoring public, provided the belts are properly manufactured and installed. The group, headed by Rep. Kenneth Roberts (D—Alabama), made no suggestions for any legislation, however. It stated: "The subcommittee feels that if the public has the opportunity to review the facts, it will recognize the great safety value in using a seat belt." A number of medical witnesses testified at hearings in the last session.

Committee Appointed to Study Medical Research, Education

Secretary Folsom has named a special committee of medical leaders and industrialists to advise him on the "status and future needs" of medical research and education. He asked the members to study such questions as:

1. Impact of expanding research programs on medical education.
2. Availability of scientists, technicians, and facilities.
3. Relative emphasis given to research in the various disease fields.
4. Relative emphasis given to fundamental studies in the basic sciences generally.
5. Relationship between federal and private research programs.
6. Standards for approval of research projects.

Chairman of the committee is Dr. Stanhope Bayne-Jones, former Yale Medical School dean and more recently president of the New York Hospital-Cornell Medical Center joint administration board and head of medical research and development for the Army.

Other members are: Dr. George Packer Berry, dean, Medical School, Harvard University; Thomas P. Carney, vice president, Eli Lilly and Company, Indianapolis; Dr. Lowell T. Coggeshall, dean, division of biological sciences, University of Chicago and formerly special assistant to the HEW Secretary; Fred Carrington Cole, vice president, Tulane University, New Orleans; Samuel Lenher, vice president, E. I. duPont de Nemours and Company, Wilmington; Dr. Irvine H. Page, director of research, Cleveland Clinic Foundation; Robert C. Swain, vice president in charge of research and development, American Cyanamid Company, New York; Dr. Stafford L. Warren, dean, school of medicine, University of California Medical Center, Los Angeles; James Edwin Webb, president and general manager, Republic Supply Co., Oklahoma City, former Under Secretary of State and former director of the Bureau of the Budget.

In announcing the committee, Secretary Folsom said:

"The medical research programs of this Department and of the Nation generally have expanded very rapidly over the past decade and have con-

little
How to win friends ...



The Best Tasting
Aspirin you can prescribe.

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tributed substantially to advances in the health of the American people.

"We are deeply interested that our medical research efforts continue to make a maximum contribution based on wise policies and sound administration. In view of the increasing magnitude of the total medical research effort and how much is at stake in its progress or shortcomings, I have decided to appoint several distinguished consultants to review not only the department's activities in these fields but the situation in medical research and medical education in the country as a whole."

Directory Published on Research Study Groups

National Science Foundation has published a 27 page directory of committees and councils that advise Federal agencies in research and development. The armed services, Atomic Energy Commission, Veterans Administration and Department of HEW are among the foremost utilizers of consultative groups in health sciences. Single copies of the guide ("Advisory and Coordinating Mechanisms for Federal Research and Development") may be obtained gratis upon request to NSF.

Scope of Hill-Burton in 10 Years Depicted

Statistical review and analysis of Hill-Burton program, just published by Public Health Service, illustrates anew the vast sweep of this pioneering phenomenon in government assistance for construction of hospitals and health facilities. The law itself is 11 years old this month and it is just 10 years ago that the first grant was awarded, setting off an operation that is now a multi-billion dollar undertaking. The summary report issued by PHS discloses that 3,514 projects have been approved to date, with a total estimated cost of \$2,874,587,085. Federal contribution is approximately one-third of that sum.

Number of new hospital beds completed or under construction is 152,593, of which 121,456 are in general hospitals; 13,245 in mental; 7,118 in tuberculosis; 7,064 for chronic disease patients, and 3,710 beds in nursing homes. Fifty-six per cent of the new hospitals have fewer than 50 beds and 22 per cent have more than 50 but less than 99.

Southern States account for 50 per cent of Hill-Burton projects. Fifty-three per cent of the total are in communities with 5,000 or less population;

only 13 per cent are in cities of 50,000 or larger. Of the 1,111 completely new general hospital projects, 51 per cent are in areas which had no hospital previously.

Serious Penicillin Reactions Increasing, FDA Reports

Reporting on a nationwide survey of more than four years, Food and Drug Administration physician told the Fifth Annual Symposium on Antibiotics that the number of serious reactions to penicillin has been increasing annually. Dr. Henry Welch, chief of the FDA division of antibiotics, made the report.

Since 1945, Dr. Welch said, isolated reports of penicillin reactions with a relatively high percentage of fatalities have been appearing in medical literature. The survey, covering the principal antibiotics, showed a substantially higher number of reactions to penicillin than to other antibiotics.

In the survey, 3,419 case histories of severe reactions were classified, but 424 were excluded because of insufficient data. One third of the reported reactions to all antibiotics were classified as life-threatening and about nine-tenths were attributed to penicillin.

"The trend of increase in serious reactions, especially from penicillin given by intramuscular injection," the FDA says, "shows there should be a clear-cut indication of need before the drug is administered. The study of case histories indicates that there has not been indiscriminate use of penicillin by physicians." At one point Dr. Welch points out that the number of reactions to penicillin is still small when considering that millions of persons receive it each year and that it has saved tens of thousands of lives. He said the increased incidence of reactions is to be expected in the wise use of a highly antigenic substance.

In connection with the symposium, a group of physicians and pharmacologists discussed a new product that was described as an antidote to penicillin poisoning.

No Flu Vaccinations Under Medicare Civilian Program

Private doctors operating under Medicare will not be authorized to give Asian flu vaccinations at government expense, but dependents may receive free vaccinations at military hospitals and clinics.



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P.S. If you wish, you may have Automatic Announcing Service, only, to inform callers where you expect to be or whether another doctor is taking your calls.

Explaining the policy, the Army's Office for Dependents' Medical Care says:

"Immunization for this disease is a procedure normally administered on an outpatient basis. Consequently, dependents, including those receiving obstetrical and maternity care, will not be eligible to receive influenza vaccine at Government expense, except as may be provided for in medical facilities of the uniformed services. A recent resolution of the State and Territorial Health Officers indicates that immunization for infants under three months of age is not recommended. Therefore, influenza vaccine for newborn is not authorized at Government expense . . ."

PHS Committee Advises One cc. Shot of Asian Flu Vaccine

A Public Health Service advisory committee has recommended that adults be vaccinated with one cc. of Asian influenza vaccine, but says that two doses of a tenth of a cc. each are acceptable for children under the age of five. The children's doses should be given a week apart, injected intracutaneously, PHS says. In September an American Medical Association committee recommended that "each physician decide for himself" whether to use one cc. subcutaneously or one-tenth of a cc. intracutaneously for both adults and children.

Veterans Administrator Scores Doctors on Medical Care Attitude

Veterans Administrator Harvey Higley has told the American Legion that some medical men now apparently believe that the public is no longer greatly concerned with the veteran and his problems. "And so they no longer hesitate to attack medical care for veterans, with particular reference to those having nonservice-connected disabilities." Ten years ago, "there were few who would challenge the legislation, in effect since 1924, which provides that a veteran with a service-connected disability has the right to enter a VA hospital if he cannot pay for the care elsewhere and if the VA has a bed available," he told the Legion Convention in Atlantic City.

His solution: a firm legislative policy on VA hospitalization, something he said he has been seeking for many months. Commented Mr. Higley: "So long as a definite policy is lacking, requests for new

and additional beds will receive little if any consideration." He then reiterated his plans for settling on a level of 125,000 authorized beds in VA hospitals.

Mr. Higley said that if the policy is to rule out care of nonservice-connected cases, this should be frankly stated so that states, counties and cities may take up the load.

He placed the number of nonservice-connected veterans on the waiting list at 22,000 of whom 17,000 are suffering from mental illness. He proposed the closing down of 3,906 unneeded tuberculosis beds and their replacement with 3,300 other beds. New construction would include a 1,000 bed hospital in Gainesville, Florida, which Mr. Higley said he was confident could be staffed "contrary to our situation elsewhere." Other hospital needs: 250 bed addition to hospitals at Coral Gables and Bay Pines, Florida; a new 300 bed unit in southern Texas, and 500 bed addition in southern California. These last three would be general medical and surgical beds.

Because nearly 5,000 of the mentally ill veterans are in the New York City area, a 500 bed addition at Montrose, N. Y., would be needed at a minimum, according to Mr. Higley.

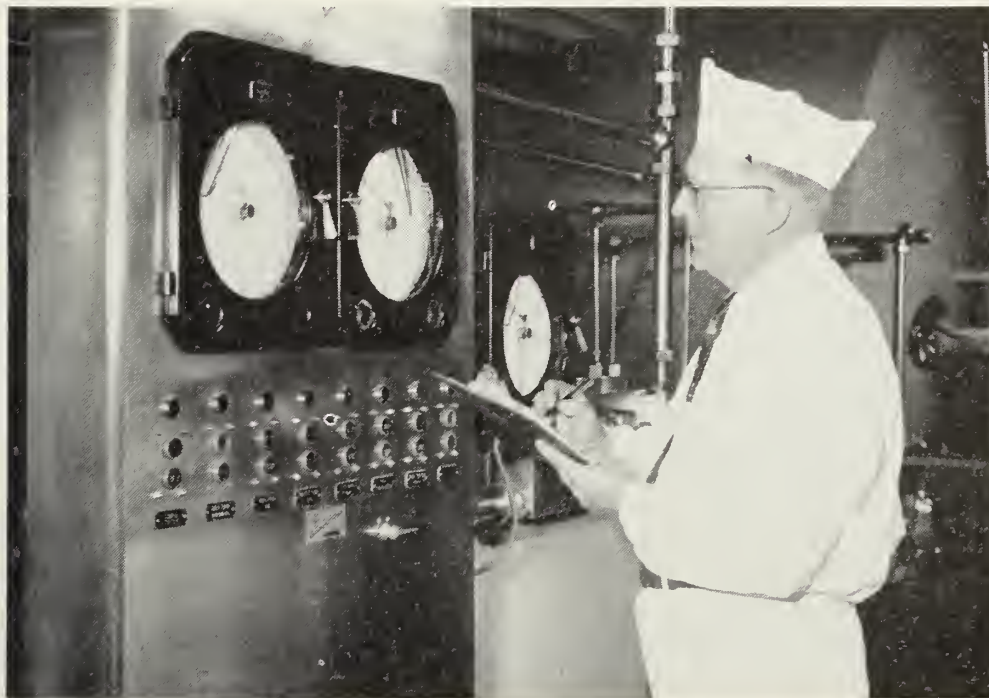
U. S. Will Buy Radiation Equipment for Colleges

Professional schools, colleges and universities are coming in for new Federal subsidies. U. S. Atomic Energy Commission is launching a program which will make them eligible for up to \$250,000 each in grants for the purchase of specialized radiation equipment and teaching aids in radiobiology. Schools of medicine, public health, veterinary medicine, pharmacy and agriculture are prospective recipients, together with departments of biophysics and biology in colleges and universities. The new enterprise is an extension of AEC's broad activities to stimulate application of nuclear technology in the life sciences.

Hill-Burton Reports Shows U. S. Hospital Bed Needs

This country needs 888,734 more hospital beds to meet the needs, according to a statistical study made by that division of Public Health Service which administers Hill-Burton program. Number

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of existing beds is estimated at 1,289,355, of which 188,928 are classed as nonacceptable on basis of fire or health hazards. Greatest shortages are in mental hospital beds—should be doubled, to 825,000—and chronic. In this latter category, acceptable beds total 44,345 and there should be more than 308,000, according to the states' plans for hospital expansion. All of these figures are exclusive of Federal hospital beds.

Fogarty Predicts Active Year in Health Legislation

Rep. John Fogarty (D—Rhode Island), chairman of the House Appropriations subcommittee on the HEW budget, is counting on a busy year in the health field during the second session of Congress. In an address to the American Hospital Association annual convention, the Rhode Island congressman placed federal construction aid to medical schools high on the list of bills due for action. He made no mention of the labor-backed bill for free hospitalization for the aged under social security.

Mr. Fogarty believes the Hill-Burton hospital program cannot continue indefinitely within the limits of its present pattern of operation, but should be used to meet future health needs. The present law expires June 1959 and in all likelihood legislation will be introduced next session for another five year extension of the program now in its 12th year.

Within the next 25 years, hospitals will be providing at least as much preventive service as curative service, according to Mr. Fogarty. Hospitals, "in fact, are moving closer each moment to the day when hospitals will be the focal point of health services for all of us throughout our entire lives."

On the role of government in health, Mr. Fogarty had this comment: "It is now generally accepted that the health of our people is a major national resource and that the government, therefore, has a direct responsibility for the health of everyone . . ." AHA made Mr. Fogarty an honorary member, citing his efforts in medical research funds and health facilities.

Future Legislation

When Congress returns January 7, one of the measures waiting its attention will be a bill to control union welfare funds through registration and publicity. (Most funds involve medical-hospital benefits.)

Jenkins-Keogh legislation, for deferment of income taxes on money put into retirement plans by the self-employed, now is assured of a hearing next year when the House Ways and Means Committee goes into all phases of taxation.

Folsom Health Aide Lists Medical Needs, Cites Problems of Aged

Secretary Folsom's special assistant for health and medical affairs, Dr. Ains C. McGuinness, has outlined some major health items which may serve as the framework of the administration's health goals for the 1958 session of Congress. In an address in Maine at the dedication of a new chronic disease and rehabilitation facility, Dr. McGuinness made these points:

HEALTH AID TO THE ELDERLY

The principles of voluntary insurance should be applied to the prepayment of medical expenses of a higher proportion of elderly people; the administration feels voluntary health insurance can advance this goal most effectively, PHS also plans to develop demonstrations of home-care services, health maintenance clinics and restorative services. (Several bills now in Congress would offer hospitalization to OASI beneficiaries.)

HOSPITAL CARE COSTS

Physicians must constantly ask themselves if they are putting a patient in a hospital when he could be served as well or better on an ambulatory basis. It is essential the problem of rising hospital care costs be solved.

RURAL HEALTH

In the more rural areas where hospital facilities might not be available at all, the most essential health services could be provided through diagnostic and treatment centers. (Several proposals have been made for Hill-Burton-type grants for clinics separate from hospitals. Under present law diagnostic and treatment centers must be owned by a state, political subdivision or public agency, or by a corporation or association that owns and operates a nonprofit hospital.

HOSPITAL ROLE IN MEDICINE

General hospitals must broaden their services and achieve greater coordination. The term "hospital care" should include not only bed care but diagnostic service and service to ambulatory patients as well.



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FROM OUR EXCHANGES

Brock is the authority for the statement that "surgery can now offer sufficient relief with a relative low mortality (10-15 per cent) to make it thoroughly justifiable to refer patients for operation" in cases of aortic stenosis ("The Surgical Treatment of Aortic Stenosis," *Brit. Med. Jour.*, 5026, pp. 1019-1028).

Clinical assessment of each case is important. Percutaneous puncture of the left ventricle is a simple, safe and quick way of determining the pressure gradient across the valve.

Various operative approaches are discussed. For noncalcified cases the open aortic valvotomy under direct vision is preferred. For calcified aortic stenosis the transventricular route is preferred.

Sir Brock has operated on 130 cases, 34 being examples of combined mitral and aortic stenosis. The mortality of the operation "need to be no more than 10-15 per cent." A good result was obtained in about 70 per cent of the survivors. The mortality will always be high if operation is deferred until features of heart failure have appeared.

Comment: The decision to operate or not to operate in aortic stenosis appears to be a simple one for the cardiac surgeon. He seems to favor an early operation on all cases unless the situation is obviously hopeless. For the internist the answer, however, is loaded with difficulties. It is his responsibility to advise the patient who is not too badly off subjectively to undergo an operation that has a considerably high mortality rate and that does not always have a favorable outcome symptomatically. It can be a hard decision to make at a time that is favorable for the success of the operation.

* * * *

Under the title "Diverticula of the Oesophagus" Mustard describes 75 oesophageal diverticula (*Canad. Med. Assoc. Jour.*, 76:10, pp. 882-831).

Most important in the group were the "pharyn-

geal" diverticula which have their origin in the midline of the cricopharynx muscle. They occur most frequently in men and usually after 50 years of age. They are probably "pulsion" diverticula. The most common symptom is regurgitation but some degree of dysphagia ultimately develops in most cases. Radiological examination easily confirms the diagnosis. Complete excision of the sac should be performed.

Epibronchial (mid-thoracic zone) are small, conical and symptomless. Usually they are an incidental finding on radiological examination of the upper gastrointestinal tract. There is evidence that at least some of them are traction diverticula. Large diverticula when flask shaped may produce symptoms such as dysphagia and chest pains. In these last cases surgical excision should be seriously considered.

Epiphrenic diverticula are usually associated with difficulty in swallowing, and often with substernal and epigastric pain. They are commonly on the right side of the oesophagus and from 6 to 8 cm. above the diaphragm. Their cause is unknown. A significant number of these diverticula are associated with cardiospasm or hiatus hernia. If the diverticulum is large and the symptoms are troublesome, surgical excision should be advised.

* * * *

"Perhaps one cannot say that gallstones cause cancer of the gall bladder but the occurrence of the two together is too great to be only a coincidence." Todd assembles a considerable amount of evidence to support his thesis (*Jour. Ky. State Med. Assoc.*, 55:5, pp. 419-426). It is hardly necessary to write that he favors the removal of the so-called "silent stones." It is difficult for Dr. Todd to visualize "how anyone can advise a patient to leave their gallstones alone because they are 'silent'." It is an old controversy and one that the author argues, for his own viewpoint, in a very persuasive manner.

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Mrs. J. Alfred Wilson, Meriden

President Attends Pennsylvania Meeting

Mrs. Paul W. Tisher attended the annual meeting of the Woman's Auxiliary to the Medical Society of the State of Pennsylvania held at the Penn-Sheraton Hotel, September 16-18. She gave an interesting report at the September 30 Board of Directors meeting. Mrs. Tisher also expressed her appreciation for the opportunity to attend this Pennsylvania Annual Meeting.

1957 Conference in Chicago

The Fourteenth Annual Conference of State Presidents, Presidents-Elect, and National Committee Chairmen was held in Chicago on Monday, Tuesday and Wednesday, October 21-23. Monday and Tuesday were spent at the Drake Hotel. The Wednesday program was held at AMA headquarters and included demonstrations and discussions on the use of films and audiovisual aids. Members of the Conference were guests of the American Medical Association at luncheon on Wednesday.

"Health is a Joint Endeavor," the theme of the national president for 1957-58, was the keynote of the Conference. Emphasis was placed on the "how to do it" idea in implementing the auxiliary program.

David B. Allman, president of the AMA, was the guest speaker, while Ernest B. Howard, assistant secretary, presented up-to-date AMA happenings. Council and bureau heads of AMA were resource authorities in the discussion groups. On Sunday evening preceding the Conference, from seven to ten o'clock, a training program for the service teams for discussion groups was conducted. Conference members were invited to volunteer for the "service team."

The Board of Directors and National Committee

Chairmen held an all-day meeting Sunday preceding the service team training program.

Connecticut was represented at this Conference by Mrs. Paul W. Tisher, president; Mrs. Charles M. Gratz, president-elect; and Mrs. F. Erwin Tracy, constitutional secretary, Woman's Auxiliary to AMA.

A detailed report of the Conference was given at the Semi-Annual Meeting, November 6, Hotel Statler, Hartford.

Semi-Annual Meeting

The Semi-Annual Meeting of the Woman's Auxiliary to the Connecticut State Medical Society was held November 6, Hotel Statler, Hartford.

Mrs. Paul C. Craig, president, Woman's Auxiliary to American Medical Association, was the guest speaker. Reports from the county presidents and the president-elect on the Chicago Conference were also given at the morning session.

During luncheon the members were entertained with a Style Show put on by Town and County, West Hartford. Members from the Hartford County Auxiliary were models for the Show.

The afternoon session was highlighted by a speaker from the "Connecticut Commission on Alcoholism."

County News

FAIRFIELD

First board meeting was held at the home of Dr. and Mrs. William Sinton on Tuesday, June 18. Chairmen from last year's group were invited to transfer material and notes to the current county board. The duties of each chairman as described in the Handbook were discussed and handbooks were

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donated to all who had not previously received them.

Ways and Means Chairmen, Mrs. Charles Sheard of Darien and Mrs. William Stahl of Danbury, suggested that a series of small individual fund-raising parties be given by members throughout the county. This was a summer social project intended to "swell" the treasury and notices were mailed to all members.

Events and experiences at the National Convention in New York were described by Mrs. Charles Murray Gratz of Greenwich.

The second board meeting was held on Tuesday, September 17, at the home of Dr. and Mrs. Charles Sheard of Darien. It was decided to build the fall meeting around the aims and purposes of our Auxiliary. In relation to this it was agreed to invite our State President, Mrs. Paul Winslow Tisher of New Britain, to speak on the correlation of state and county projects. The film, "Doubting Doctor," will also be shown. Plans for the following events were also made:

September 14—Booth at the Harmony Grange Fair in Monroe. *Today's Health* was distributed, and a display entitled "How to get a Doctor in an Emergency" was set up.

September 28—Booth at the Danbury Fair. Auxiliary will assist the physicians in supplying volunteers under the chairmanship of Mrs. G. R. Eckert of Danbury.

October 8—Semi-Annual Meeting, Chimney Corners, Stamford; Chairman, Mrs. Eugene Brochu of Danbury.

October 9—Nurse Recruitment Tea, St. Vincent's Hospital, Bridgeport, under chairmanship of Mrs. Anthony Apuzzo of Fairfield.

October 12—Annual Dinner Dance, Shorehaven Golf Club, East Norwalk. Benefit of Recruitment and Scholarship, Chairmen, Mrs. Charles Sheard of Darien and Mrs. William Stahl of Danbury.

November and December—Collection of Christmas gifts for patients at Laurel Height TB Sanatorium under direction of Mrs. Rolando Ruiz of Danbury.

Publicity—We have been given a Woman's page in our County Capsule. (Fairfield County Medical Society News.)

Paid membership: 248.

Bonnie Sinton
Mrs. William Sinton

HARTFORD

The total paid membership is 499.

The Rummage Sale, which is our main money-raising project was held October 11, at the West Hartford Armory. A Newsletter, calling attention to the Rummage Sale, as well as our handbook, was mailed to the membership the first week in September.

Al Capp, the famous cartoonist, was the guest speaker at the semi-annual meeting held at the Hunt Memorial, Hartford. A buffet luncheon was served.

Plans are under way for the annual Medi-Capers. The dance will be held on January 18.

Today's Health committee, in an effort to stimulate additional subscriptions, is mailing a letter to all members by the first week in October. A stamped return envelope is being enclosed.

Civilian Defense and Safety chairman has been notified of a meeting on Fire Prevention to be held sometime in October, sponsored by the Hartford Health Department.

Medical and surgical supplies are being collected at central points for distribution.

All other committees are active and planning their year's work.

Diane A. Marinaro
Mrs. Nicholas Marinaro

NEW HAVEN

Letters went out in October to the membership urging participation in the four features for this year, namely,

- Increased subscriptions to *Today's Health*.
- Interest and support for AMEF.
- Promotion of safety measures.

Study of legislation effecting health and medical care.

Enclosures included: the program of the year's events, subscription blanks for *Today's Health*, Safety pamphlets, and a copy of the revised constitution.

Because of the popularity of last year's Demonstration and Workshop for Holiday Decorations, we have scheduled Mrs. Van Leuvan for a return date on November 15. The entrance fee is a contribution to our Scholarship Fund.

The Semi-Annual Meeting, October 22, will feature a panel discussion by wives of foreign background.

Katharine W. Wakeman
Mrs. Edward Wakeman

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SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL

Medical Education Program for Noon Conferences for November, 1957

Friday, November 1

Grand rounds

Monday, November 4

Clinical pathological conference

Wednesday, November 6

Tumor clinic, 10:00 A. M.

Friday, November 8

Grand rounds

Monday, November 11

Paul Beeson, M.D., professor of medicine, Yale University School of Medicine

Pyelonephritis

Friday, November 15

Grand rounds

Monday, November 18

Mark A. Hayes, M.D., associate professor of surgery, Yale University School of Medicine

Management of perforated duodenal ulcer

Friday, November 22

Grand rounds

Monday, November 25

No meeting—holiday week

Wednesday, November 27

Gilbert Glaser, M.D., associate professor of neurology, Yale University School of Medicine

Cerebral vascular disease

Friday, November 29

No meeting—holiday week

THE NEWINGTON HOME AND HOSPITAL FOR CRIPPLED CHILDREN

Newington, Connecticut

The clinical programs for November and December 1957 will be scheduled as follows:

Monday, November 11, 7:30 P. M.

The development of tendon surgery

Dr. Leo Mayer, New York City

Monday, December 9, 7:30 P. M.

Orthoroentgenography

Dr. Jaime M. Benavides, chief resident

Open reduction in dislocation of the hip

Dr. Louis A. Coulson, New London

CONNECTICUT TRUDEAU SOCIETY

The Annual Fall Meeting of the Connecticut Trudeau Society will be held at the Gaylord Farm Sanatorium, Wallingford, Connecticut, on Thursday, November 14, 1957. Once again this will be a consecutive case conference presentation.

This year the Connecticut Trudeau Society has invited the staff of St. Albans Hospital of Long Island, New York, and the staff of Laurel Heights Sanatorium of Shelton, Connecticut, to be participating hospital groups. Dr. Robert L. Yeager, superintendent and medical director of Summit Park Sanatorium in Pomona, New York, has agreed to act as moderator of the session.

The following is the program schedule:

10:00 A. M. - 1:00 P. M.

Morning session—medical and surgical cases

1:00 P. M. - 2:00 P. M.

Luncheon at Gaylord Farm

2:00 P. M. - 2:30 P. M.

Business session

2:30 P. M. - 5:30 P. M.

Afternoon session—diagnostic problems

6:30 P. M.

Dinner at Gaylord Farm

The Connecticut Trudeau Society extends a cordial invitation to attend this meeting to interested physicians.

SECOND CONNECTICUT CONFERENCE ON PHYSICIANS AND SCHOOLS

Thursday, November 14, 1957

Manchester High School

134 Middleturmpike, Manchester, Connecticut

2:00 Registration.

2:30 General Assembly.

3:15 Group Discussions:

Group I A & B Problems of School Administration
Relating to School Health

II A & B Health Appraisal of Pupils, Records,
Applications

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- IV A & B Schools' Role in Assisting Pupils with Emotional Problems
- V A & B Value & Function of a School Health Council.

5:30 Dinner.

6:30 General Assembly—Reports from discussion groups.

7:30 Discussion of Reports.

8:45 Adjournment.

Sponsored by: Connecticut State Medical Society, Connecticut State Dental Association, State Department of Health, State Department of Education, Connecticut School Superintendents' Association.

Pan Pacific Surgical Congress
Honolulu, Hawaii
November 14-22, 1957

Inter-American Congress of Pan American Medical Association
Mexico City, Mexico
November 18-22, 1957

MENTAL HEALTH CONFERENCE, NOVEMBER 22-23

The fourth annual AMA Conference on Mental Health will be held at the Drake Hotel, Chicago, November 22 and 23. Four discussion topics will cover: (1) The role of the general practitioner in relation to a specific psychiatric case; (2) Blue Cross-Blue Shield and other voluntary health insurance plans for the psychiatric patient; (3) Relationship of the psychiatrist in private practice to the general hospital in his community; (4) Psychiatric and related mental health problems in industry.

Dr. Leo H. Bartemeier, chairman of the AMA Council on Mental Health, will welcome the mental health representatives from state medical societies.

Dr. Manfred Guttmacher of Baltimore will be the guest speaker at a dinner meeting on November 22. His subject will be "The Role of Psychiatry in Relation to the Problem of Capital Punishment."

AMA COMMITTEES SCHEDULE MEETINGS

Two committees of the AMA Council on Medical Service plan regional meetings Monday, December 2, in Philadelphia just prior to the AMA's 11th Clinical Session. The Committee on Maternal and Child Care—first regional meeting on perinatal mortality and morbidity. Invitations are being sent to members of maternal and child care committees in Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Vir-

ginia. The Committee on Aging—third regional conference for members of state committees on aging. Subjects to be discussed include physical examinations and a health maintenance program, guides for the organization and operation of medical society committees on aging, medical education in caring for the aged, preretirement counseling, and special research programs of a medical school.

Physicians interested in attending either of these sessions should contact the Council for further details.

COURSE ON ALLERGY

Dr. Herbert J. Rinkel of Kansas City, Missouri will conduct a three day course on Inhalant and Food Allergy in Akron, Ohio on December 6, 7, 8, 1957. Other lecturers will be Dr. D. E. Cowen of Denver, Colorado and Dr. Dor Brown of Fredricksburg, Texas. This course is being sponsored by The Akron Academy of Ophthalmology and Otolaryngology. For further information and reservations contact Dr. Richard H. Stahl, 2674 North Haven Boulevard, Cuyahoga Falls, Ohio.

FOURTH BAHAMAS MEDICAL CONFERENCE

The Fourth Bahamas Medical Conference will be held at the Fort Montagu Beach Hotel in Nassau, Bahamas, December 1-15, 1957. A copy of the program is attached.

The Bahamas Medical Conferences offer busy doctors an opportunity for an unrivalled vacation combined with an excellent medical program.

Ample time is reserved for recreational activities. Lectures and clinics are so arranged as to keep most of the day free for the enjoyment of Nassau's beauty and facilities.

Participants in the Fourth Bahamas Medical Conference and their parties are entitled to special rates at the Fort Montagu Beach Hotel: 14 dollars per day, per person, two in one room; 18 dollars per day, per person, one person in one room. These rates include room and three meals: breakfast, lunch and dinner.

Reservations should be made by writing directly to Mr. John L. Cota, General Manager, Fort Montagu Beach Hotel, Nassau, Bahamas. Ten cent stamp for air mail.

The registration fee is 75 dollars. Cheques should be made out to the order of "Bahamas Medical Conference," and should be sent to Mr. Cota when making reservations.

An official certificate of attendance at the Conference will be issued. No arrangements have been made yet to have the Bahamas Medical Conference approved for credit by the American Academy of General Practice.

American and Canadian citizens do not require passports for travel to the Bahamas. Vaccination certificates are not required.

There are direct flights to Nassau from New York, Toronto and Florida. There is also a weekly boat service from Miami to Nassau.

There are no tropical illnesses in Nassau.

The temperature in December is around 70° F.

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AMA TO CO-SPONSOR SYMPOSIUM AT AAAS MEETING

A program on normal and abnormal aspects of the skin will be sponsored jointly by the AMA's Committee on Cosmetology and the Society for Investigative Dermatology December 28-29 during the 124th annual meeting of the American Association for the Advancement of Science in Indianapolis. The two-day symposium entitled "The Human Integument—Normal and Abnormal" will be presented before the medical sciences section of the AAAS. Four major topics will be discussed: (1) The Integument as an Organ of Protection; (2) Circulation and Vascular Reactions (3) Sebaceous Gland Secretion, and (4) Pathogenetic Factors in Pre-malignant Conditions and Malignancies of the Skin.

Dr. Stephen Rothman of Chicago, chairman of the AMA Committee, will serve as symposium chairman. Further details may be obtained by writing directly to the Committee on Cosmetology.

THE AMERICAN FOUNDATION FOR ALLERGIC DISEASES

801 Second Avenue, New York 17, N. Y.

Announcement of post-doctoral fellowships in research and clinical allergy for two years each.

Stipend: first year, \$4500; second year, \$4750; laboratory and travel expenses for two year period, \$750.

Requirements: Candidates must be graduates of approved medical schools and must have completed one or two years of the graduate training required as a preliminary to certification by the Boards of Internal Medicine or Pediatrics; they are to divide their time between research and clinical training, and in the second year 10 or 15 per cent of a candidate's time might be devoted to teaching. The respective Institutions have taken the necessary steps to have this training credited toward the Subspecialty in Allergy by the Board of Internal Medicine and the Board of Pediatrics.

Requests for applications should be sent directly to one of the following, in whose field the candidate would like to work: Dr. Colin M. MacLeod, Professor of Research Medicine, University of Pennsylvania, 820 Maloney Clinic, 36th and Spruce Streets, Philadelphia 4, Pennsylvania; or Dr. Herman N. Eisen, Professor of Medicine (Dermatology), Washington University School of Medicine, 600 South Kingshighway, Saint Louis 10, Missouri.

Applications should be filed no later than December 15, 1957 with any of the above. Notification will be mailed to successful candidates by February 1, 1958.

STUDY UNITS

Yale University School of Medicine 1957-1958

Study Units are organized to conduct research and to carry out educational programs in fields which overlap the usual departmental boundaries. The meetings are devoted to seminars, to reports of the results of investigations by the members to discussion of problems, and to lectures. Because changes in schedules sometimes occur, those planning to attend should check directly with the Chairman of the particular Study Section to confirm time and place of meeting and to be placed on the mailing list of the Study Section. Brief descriptions of the organizations follow:

ARTHRITIS STUDY UNIT

Made up of faculty members in fundamental and clinical fields of medicine related to arthritis. The purpose of this Unit is to stimulate teaching and research in arthritis, and to hold conferences at which scientific papers are presented by members of the Unit and by invited speakers. Chairman: Dr. G. K. de Forest (309 Edwards Street). Third Thursday of each month, 3:30-4:30 P. M., Fitkin Amphitheater.

CARDIOVASCULAR STUDY UNIT

The purposes of this Unit are to further teaching, service, and research in cardiovascular medicine in the School. It conducts a program of scientific and clinical meetings throughout the academic year. Chairman: Dr. A. V. N. Goodyer. Third Monday of each month, 8:15 P. M., Fitkin Amphitheater.

GASTROINTESTINAL STUDY UNIT

This Unit will attempt to correlate physiology of the gastrointestinal tract with its diseases. During the year varying approaches to this problem will be essayed. Chairman: Dr. H. M. Spiro. Thursdays, 3:00-4:00 P. M., Trask Room (3108 LMP).

NEUROLOGICAL STUDY UNIT

The chief objective of this Unit is the integration of research on the nervous system with other neurological interests in the School. It directs a program of scientific and clinical neurological meetings where reports of studies may be presented and clinical cases demonstrated. Speakers are invited from the various centers of neurological research. Chairman: Dr. G. H. Glaser. Tuesdays, 4:30-5:30 P. M., Fitkin Amphitheater.

POLIOMYELITIS STUDY UNIT

The objective of this Unit is to direct a program of scientific investigation on acute anterior poliomyelitis and related virus infections. It is supported by a grant from the National Foundation for Infantile Paralysis, Inc., Chairman: Dr. J. R. Paul.

PSYCHIATRY AND LAW STUDY UNIT

The Unit is an interdisciplinary research, teaching, and consultation center focussing on problems which are common to psychiatry and law. Its present investigative activities are in the areas of anti-social, sexual, and aggressive behavior, and community sanctioning policies. Chairman: Dr. L. Z. Freedman.

(Continued on next page)

when anxiety and tension "erupts" in the G. I. tract...

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FOR SALE—Lily biological refrigerator, like new \$125.00—Spencer hb. hemoglobinometer \$40.00—Small electric cast cutter \$30.00—Yeoman illuminated proctoscope \$30.00—National headlight \$15.00—Microscopes \$75.00 up—Automatic autoclaves, demonstrators \$80.00 up—New Castle sterilizer, 16 inch \$75.00—Rebuilt sterilizers \$30.00 up—Rectal biopsy forceps \$30.00—All makes otoscopes \$22.00—Ophthalmoscopes \$20.00—New tycoos sphygmomanometers \$34.00—Emdee bags \$32.00—Micro-photo camera \$75.00—New short wave \$225.00—Burton examining lamp \$22.00—Hemometers \$13.00—Bausch & Lomb trial lens set in cabinet \$95.00—Ferre-Rand projectoscope, new \$75.00—Cauterys \$25.00—Cameron sigmoidoscope set \$45.00—Leg rest \$1.00—Bargains in instruments—Electric centrifuge \$38.00. Phone BEverly 7-3145 or write for information. Harry Sacker, 188 Grove Street, Meriden, Connecticut.

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STUDY UNITS—(Continued from 1028)

MEDICAL MANAGEMENT STUDY UNIT (Long-term observation of the rehabilitation of a patient)

The objective of this Unit is to enable a limited number of students to closely follow and assist in the rehabilitation of individual patients for a minimum period of one year. Rehabilitation as used here is the process which enables a patient to become as active a member of society as his capabilities will permit by developing appropriate mental, physical, vocational, and social potentials. The student starts to work with his patient in the third year of medical school under the guidance of a staff advisor. During the fourth year the student presents his patient at meetings which are held every two weeks with the assistance of his advisor and other physicians and medical associate workers who have been involved in the care of that patient. Coordinator of program: Dr. R. V. Jones, Alternate Wednesdays, 4:00-5:00 P. M., Fitkin Amphitheater.

NEOPLASM CONFERENCE

Under the supervision of the Department of Surgery, a series of conferences is planned. These conferences will cover the biology of cancer and discussions of the diagnosis and treatment of various types of tumors. Meetings are held every Tuesday at 4:00 P. M. except during vacation periods, Farnam Auditorium. Chairman: Dr. Mark A. Hayes.

LIBRARY PRIVILEGES

Any physician may have full privilege of the Medical Library by joining the Associates of the Yale Medical Library (annual contribution of \$5 or more). Those interested should apply directly to the Librarian of the Yale Medical Library.

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AROUND THE STATE

Dr. Snoke Advocates Medical and Hospital Insurance

Albert W. Snoke, president of the American Hospital Association and director of Grace-New Haven Community Hospital, in addressing the recent meeting of the Hospital Association said that widespread insurance offers the only hope for medical and hospital care for the vast majority of physicians. He pointed out that hospital costs reflect the nationwide problem of inflation and spiraling wage scales and further said: "it is about time that we realize that the situation will not improve even if we ignore it. . . . Wages and salaries will have to become competitive in this modern labor market and hospital costs will inevitably rise."

The only hope for paying for medical and hospital care "for the vast majority of the population of this country," he said, is through widespread medical and hospital insurance.

Dr. Snoke said the best type of medical and hospital program is based on voluntary insurance with payments by government for the needy.

He suggested examining the possibility of patterning health insurance so the subscriber could benefit from his policy without being in a hospital bed.

He urged organized medicine to assume greater initiative and responsibility in recognizing the problems involved in financing and paying for voluntary hospital and medical care in today's changing world.

Voluntary insurance and the hospital are the bulwarks of medical practice in this country today.

Connecticut Regional Blood Program

In many communities in this State, local physicians have volunteered to serve at Mobile Unit Operations to indicate their support of the blood program as a whole. Usually the five hour operation is covered by three physicians working approximately two hours at a time. In communities in which the total medical profession is supporting this idea, a roster

is prepared by the Medical Society which results in the donation of physicians' services at approximately two or three intervals.

The value of this procedure is not solely in the saving of money, although this is always helpful. The value lies in the fact that the donors, by seeing their own or other well known physicians of their community at the mobile unit operation, realize that the plan has local medical approval. The presence of their own physician allays the fears of donors and brings a feeling of friendliness into a situation which can otherwise be impersonal.

Further, it has been demonstrated that physicians who serve on the Mobile Unit Operations become increasingly aware of the plan's importance and its problems.

	JULY 1, 1957 THROUGH SEPTEMBER SEPTEMBER	
DONORS	1957	30, 1957
Donors accepted	7,644	21,058
Donors rejected	783	2,024
Donors registered	8,427	23,082
BLOOD ISSUED TO HOSPITALS		
To Connecticut Hospitals from Center	6,046	18,610
Blood collected by hospitals.....	524	1,563
To fractionation stock pile	153	468
To out of state hospitals.....	80	244
	6,803	20,885
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	112	308
Processed into packed cells.....	0	4
Processed into liquid plasma.....	463	1,955
	575	2,267
Discarded—unfit and broken.....	32	115
	6,410	23,267
Grand Total—distribution of blood.....	7,410	23,267
Blood returned to center for processing into plasma and fractions.....	439	1,966
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	58	154
Fresh frozen plasma (125 cc.).....	108	497
Serum albumin (100 cc.).....	101	292
Immune serum globulin (2 cc.).....	60	60
Packed red cells.....	0	4
Fibrinogen	0	0

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Medical Adviser Superintendent

Bridgeport Chapter of General Practice

Occasionally an editor misplaces material and once in a while it never reaches him. Such seems to have been the case with a notice of a postgraduate course in "Psychiatry for the Family Physician" sponsored by the Bridgeport Chapter of the Academy of General Practice. Since this course has been running since September 30 and will hold its final meeting November 25 any announcement of it is a bit passe. We hope it has proved successful in spite of the lack of support by the JOURNAL. The Bridgeport chapter is to be congratulated on its initiative in supplying a series of lectures which should go a long way in affording the general practitioner an unusual opportunity to improve his care of the patient.

More Nurses Needed

The five members of the Board of Examiners for Nursing and their terminal dates for this appointment are: Ona Wilcox, president, and Mary Brackett, 1959; Helen Marchant, secretary, and Sister M. Mechtilde Carty, 1958; and Josephine Dolan, 1960.

The Board has registered 1,322 graduate nurses and has certified 297 licensed practical nurses in 1956-1957. We have reviewed our programs of education for nurse personnel and we are happy to report that 16 of our 21 schools of nursing have now achieved national accreditation, a truly enviable record for any state.

Our nursing situation is still serious. Facts available indicate that we need expansion of our facilities for education of nurses; we need a sizeable increase in enrollment of student nurses; and we need increase in the number of prepared teachers, administrators, and supervisory personnel for our schools of nursing and our nursing services. The increased scholarship aid allocated for 1957-59 is one approach which will be helpful. The concerted effort of citizens, government, and health groups will be essential, however, if the health services of our State are to be maintained.

Congress passed legislation in 1956 which provided for the appropriation of federal funds for scholarship aid for graduate nurses to prepare for

teaching and administration in schools of nursing and for supervision and administration of nursing services. This legislation is in effect only until June, 1959, so it is essential that provision be made before that date for State funds to be made available to meet this critical shortage in our State.

Makes Hard-Hitting Speech on Doctors in Politics

At the recent eighth annual combined meeting of the New Hampshire and Vermont Medical Associations, Dr. D. Olan Meeker, of Riverside, Connecticut, a member of the AMA legislative committee, delivered a hard-hitting speech on why doctors should take a more active part in local politics.

Dr. Meeker spoke only a few hours after AMA President Allman urged the same group to help "keep the hand of state and federal government out of the doctor's medicine bag."

The Connecticut doctor devoted his entire speech to the need for physicians to enter the political life of their communities. "That is the only way," Dr. Meeker said, "that they can preserve the individual freedom which they expect as a natural consequence in their own practice."

Continuing, he said:

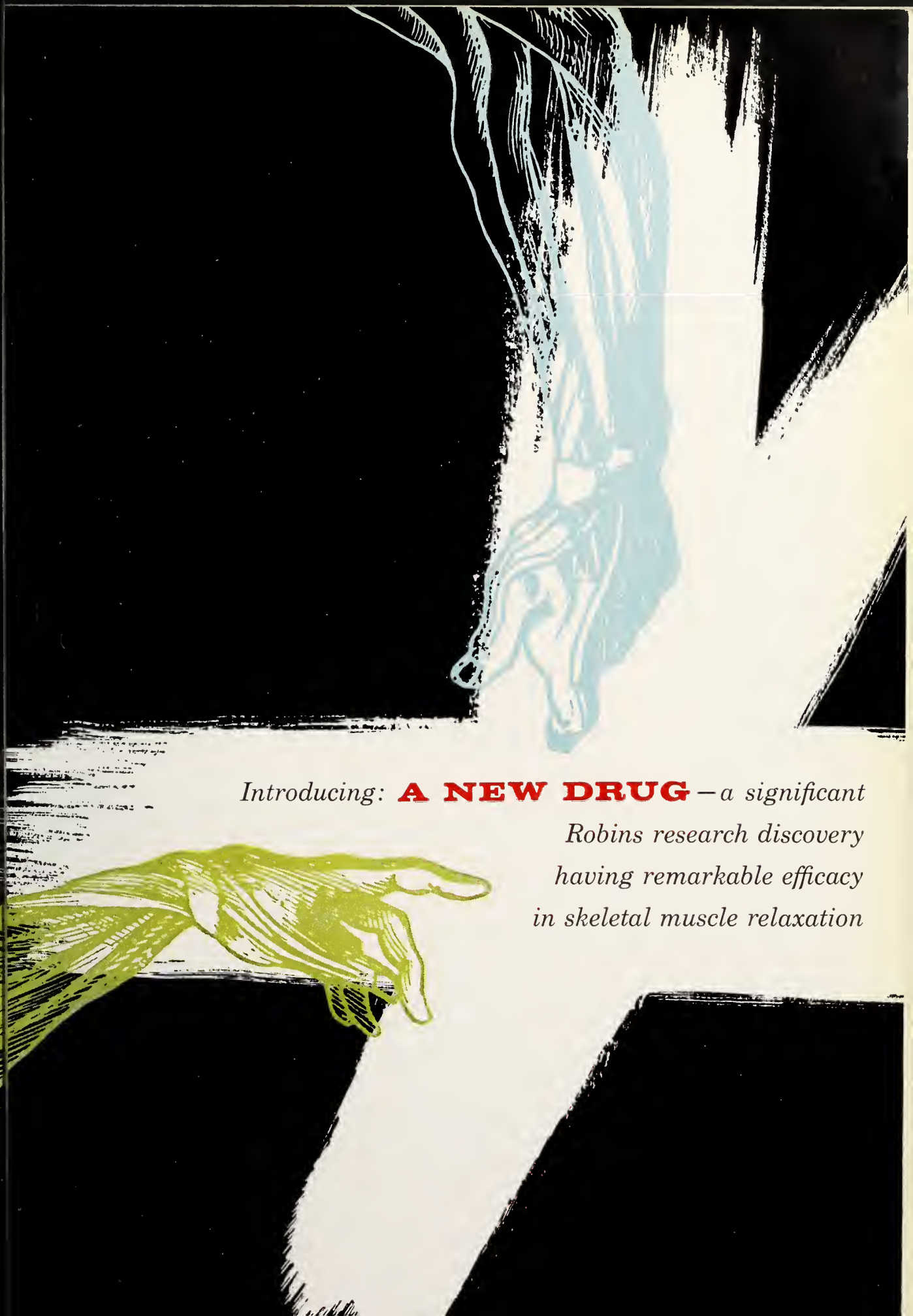
"Unfortunately many of the house staff and younger practicing physicians have become tongue-tied when it comes to talking or doing anything about politics. Some are afraid that they might antagonize patients and lose a few; others are fearful that stating their ideas on anything outside of medicine will brand them as advertisers.

"It is fortunate that physicians during the early days of this country had a different attitude about civic obligations and politics."

Fairfield County

R. Harold Lockhart, Bridgeport, president of the Fairfield County Medical Association, has appointed Edwin R. Connors, Bridgeport, chairman of local arrangements for the annual meeting of the Connecticut State Medical Society to take place in Stratford this spring. Dr. Connors is expected to name his own committee members shortly.

At the recent annual meeting of the Connecticut Chapter, American Academy of General Practice, Edwin F. Trautman, Trumbull, was elected president.

A surrealist illustration. In the lower-left foreground, a hand is shown holding a small, dark, triangular object. The hand is rendered with fine, dark lines. In the upper-right background, a face is visible, appearing to be part of a larger, more complex structure. The face has a prominent nose and is looking towards the viewer. The overall composition is abstract and dreamlike, with a focus on the hand and the face.

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in skeletal muscle relaxation

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- Highly potent and long acting.^{5,8}
- Relatively free of adverse side effects.^{1,2,3,4,6,7}
- Does not reduce normal muscle strength or reflex activity in ordinary dosage.
- Beneficial in 94.4% of cases with acute back pain due to muscle spasm.^{1,3,4,6,7}





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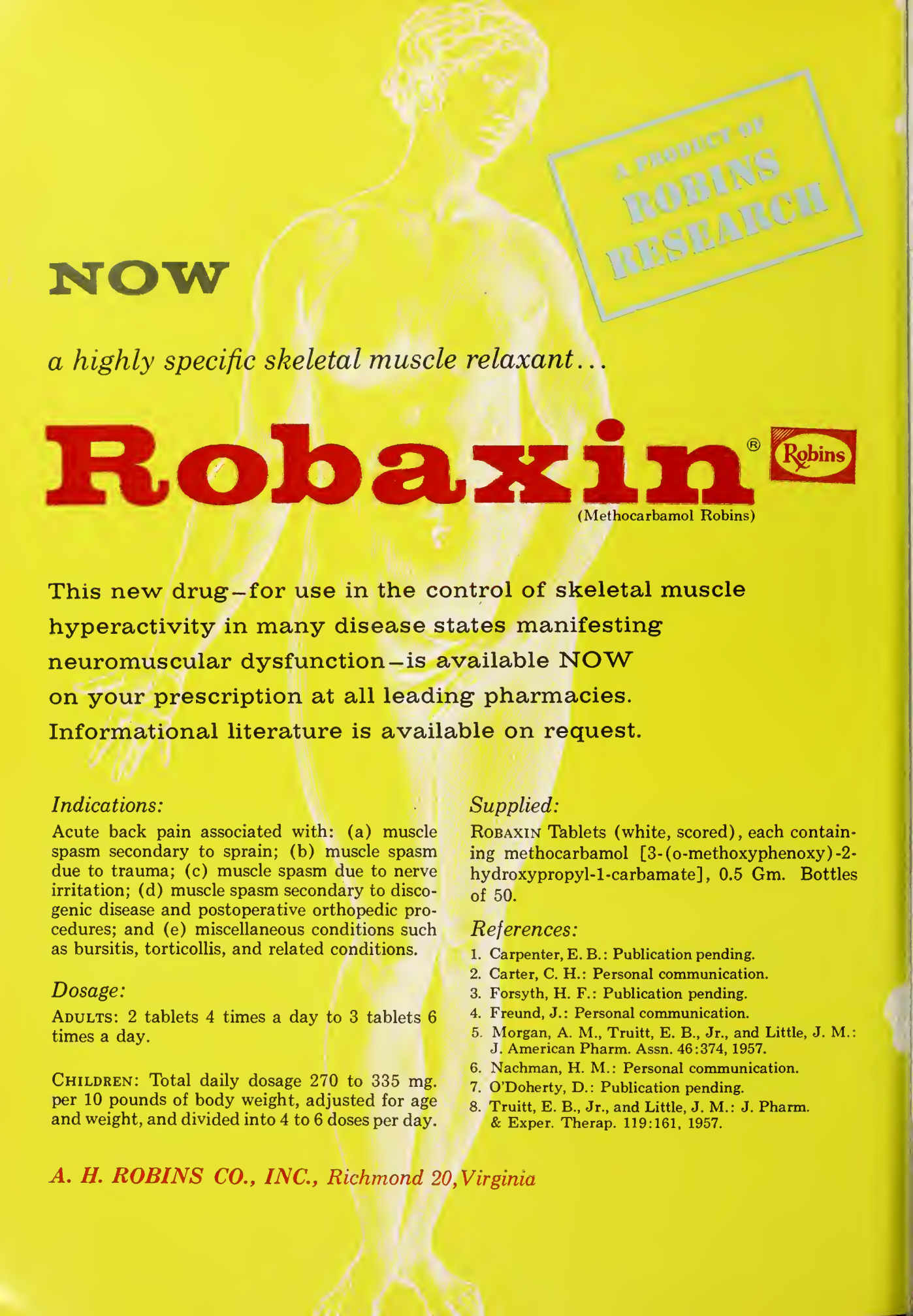
ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord — with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 — or an over-all beneficial effect in 94.4%.^{1, 3, 4, 6, 7} No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.^{1, 2, 3, 4, 6, 7}

CLINICAL RESULTS WITH ROBAXIN IN ACUTE BACK PAIN^{1, 3, 4, 6, 7}

Disease entity	No. of Cases	Duration of Treatment	Dose per day (divided)	Response				Side Effects
				Marked	Mod.	Slight	Neg.	
Acute back pain due to								
(a) Muscle spasm secondary to sprain	18	2-42 days	3-6 Gm.	17	1	0	0	None, 16; Dizziness, 1; Slight nausea, 1
(b) Muscle spasm due to trauma	13	1-42 days	2-6 Gm.	8	1	3	1	None, 12; Nervousness, 1.
(c) Muscle spasm due to nerve irritation	5	4-240 days	2.25-6 Gm	4	1	0	0	None, 5.
(d) Muscle spasm secondary to discogenic disease and postoperative orthopedic procedures	30	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25; Dizziness, 1; Lightheadedness, 1; Nausea, 2.*
Miscellaneous (bursitis, torticollis, etc.)	6	3-60 days	4-8 Gm.	6	0	0	0	None, 6.
TOTAL	72			59	6	3	4	



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Indications:

Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to disogenic disease and postoperative orthopedic procedures; and (e) miscellaneous conditions such as bursitis, torticollis, and related conditions.

Dosage:

ADULTS: 2 tablets 4 times a day to 3 tablets 6 times a day.

CHILDREN: Total daily dosage 270 to 335 mg. per 10 pounds of body weight, adjusted for age and weight, and divided into 4 to 6 doses per day.

Supplied:

ROBAXIN Tablets (white, scored), each containing methocarbamol [3-(o-methoxyphenoxy)-2-hydroxypropyl-1-carbamate], 0.5 Gm. Bottles of 50.

References:

1. Carpenter, E. B.: Publication pending.
2. Carter, C. H.: Personal communication.
3. Forsyth, H. F.: Publication pending.
4. Freund, J.: Personal communication.
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At the semi-annual meeting of the Fairfield County Medical Association held recently at the Round Hill Club, Greenwich, dues of \$22 for 1958 were approved by members upon the recommendation of the Board of Trustees. Dues of \$25 prevailed from 1955 through 1957. In other action taking place at the session, the following nominees for vacancies in the Professional Policy Committee of Connecticut Medical Service, Inc., were approved: George B. Garlick, Bridgeport, otorhinolaryngology; Gray Carter, Greenwich, internal medicine; Francis X. Foley, Bridgeport, orthopedics; Charles Sheard, Stamford, dermatology.

Hartford County

The Board of Directors of the Hartford County Medical Association, at its September meeting, stated that "current epidemiological data indicate the probability of an epidemic of Asian influenza in this area in the forthcoming months," and urged HCMA members "in local community medical societies, hospital community groups, or other groups specifically organized for the purpose, to develop immunization of the entire population against Asian influenza as rapidly as possible." The Board urged practitioners, regardless of type of practice, to make the vaccine available to their patients.

The directors also urged "public health and welfare agencies to take the necessary steps to see that their respective clients receive inoculations of Asian influenza vaccine." The Board also approved the participation by HCMA members in programs for immunization of employed groups this fall and winter.

The Board recommended that earliest consideration be given to the immunization of the aged, the pregnant, those afflicted with cardiac or pulmonary disorders and "others to whom Asian influenza would likely be a more serious threat to health than it would be to the rest of the population."

A suggestion was made that any person allergic to poultry products consult his personal physician before undergoing inoculation.

THE BOARD OF DIRECTORS

Nineteen doctors from HCMA participated recently in a golf tournament for the benefit of the nephrosis research at Yale University Medical School. They were: Vincent Turco, Timothy L. Curran, John Pulaski, Andrew Thomas, Enos J. O'Connell, Joseph Lankin, George Rosenbaum, Frank Roth, Charles Hamilton, Charles Roh, Robert

Doherty, Donald Morrison, Samuel Marranzini, Philip Goldenberg, James H. Hennessy, George Hurwitz, David S. Slossberg, John Burns and D. Norman Markley. Charles Pfizer & Company sponsored the tournament.

Former director of the Connecticut Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, Sidney Shindell was appointed recently to the post of medical adviser to the overseas headquarters of the American Joint Distribution Committee.

Francis DePasquale has retired as a brigadier general in the Connecticut National Guard, ending a 31 year military career.

Charles Goff left recently for Europe. He will be in England to set up a research project at the British Museum of Natural History, later attending the National Society of Orthopedic Surgery and Traumatology in Spain.

Last month Dr. Ralph M. Tovell of Hartford, in honor of Dr. Horace Wells, presented for the Horace Wells Club of Capetown, South Africa, a medal to a medical student in Capetown receiving the highest marks in anesthetics.

The appointment of Ralph M. Reinfrank of Wethersfield as director of the outpatient department at Hartford Hospital was announced recently by T. Stewart Hamilton, executive director of the hospital. He succeeds Philip Partington who has been named assistant medical director. The appointment of Dr. Otto Goldkamp of West Hartford in the department of physical medicine was also announced.

William B. Scovill, Benjamin B. Whitcomb, James C. Fox, Charles I. Solomon, Rebecca Solomon and Waladimir T. Lieberman returned recently from the first international Congress of Neurological Sciences in Brussels, Belgium.

DR. W. W. WRIGHT EXHIBITS PAINTINGS

William W. Wright, contemporary artist of West Hartford and a retired physician, recently held a one-man exhibit of paintings and water colors including scenes of New England and the Caribbean. Dr. Wright is a member of the Connecticut Academy of Fine Arts and the American Physician's Art Association and has been awarded many prizes. He is a former president of the Water Color Society, has exhibited at Silvermine and the Springfield Art League. His great grandfather designed Paisley shawls in Paisley, Scotland, which is Dr.

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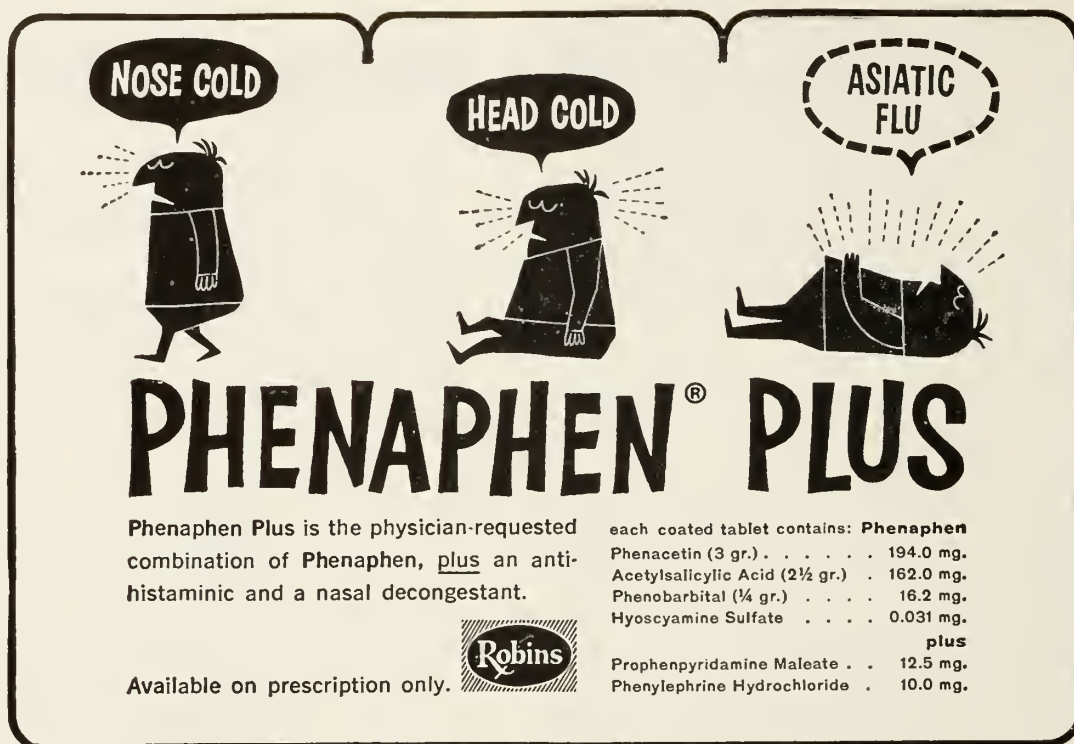
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Wright's only ancestral art claim. The exhibit took place in Fairfield County.

Litchfield County

The 193rd semi-annual meeting of the Litchfield County Medical Association was held at the Torrington Country Club, Goshen on October 1. During the business meeting, the president of the State Medical Society, our own W. Bradford Walker brought greetings from the State Society. Delegates of various county societies were present who brought greetings from their associations.

M. David Derren of Bridgeport gave us detailed information about the Retirement Plan of the Fairfield County Medical Association. This produced considerable interest in our members.

In the Professional Policy Committee of CMS the following members were elected to the following categories: Dermatology, Louis E. Garston; Internal Medicine, Benjamin Katzin; Orthopedics, Victor P. Conforti; Otorhinolaryngology, Nicholas Samponaro.

Two new members were elected to membership: Harold Fenwick Schilback and John Victor Haxo, both of New Milford.

Following dinner Mr. Henry Philip Staats of Litchfield, a world traveler, presented very interesting motion pictures of wild african game.

Middlesex County

A. W. Thomson, Jr., was recently certified by the American Board of Obstetrics and Gynecology.

Carl C. Chase died in the doctors' dressing room at Middlesex Memorial Hospital on September 17. He had practised in Chester for several years in the twenties and after training at Newark Eye and Ear Hospital he came to Middletown in 1931 and practiced his specialty there ever since.

Nicholas J. Daukas has become associated with William M. Joyce in the practice of ophthalmology in Middletown.

Christie McLeod attended the annual meeting of the American Society of Clinical Pathologists early in October in New Orleans.

Clarence Harwood attended the annual meeting of the American Academy of Pediatrics in Chicago early in October.

Anselm Schurgast has moved his office to Meriden. His practice is limited to psychiatry.

A Cooperative Life Saving Program of Physicians, Hospitals, and
Health Departments in the Field of Accident Prevention and Control

A POISON CONTROL PROGRAM FOR CONNECTICUT

ALEXANDER J. TUTTLES, M.D., M.P.H. and ROBERT J. KEEHN, B.S., M.S., *Hartford*

Item 1. A local hospital requested the Toxicological Laboratory of the Connecticut State Department of Health to analyze the contents of a bottle stating that it contained a petroleum distillate. The patient was treated in the hospital for two days but did not respond and condition was critical. The hospital was notified that the bottle contained chloroform and not petroleum distillate. After a change in treatment the patient responded and made an uneventful recovery.

Item 2. An 18 month old boy was taken to the hospital after swallowing many pills from his mother's box of prescription medicine. The Stamford Poison Center was asked for information as to the so-called tranquilizer drug, supposedly a depressant. It was identified as a stimulant and the attending physician was advised to give a sedative and to watch for convulsions within two hours. Child was hospitalized and within two hours became very hyperactive and went into violent convulsions. Intravenous sedation controlled the convulsions and child improved rapidly.

Item 3. An 18 month old boy was taken to the emergency room of a local hospital after swallowing some furniture polish. The boy's stomach was washed out and he was released. The following evening the boy was readmitted to the hospital in a critical condition and died the following morning from bilateral pneumonia.

Item 4. A nurse of a practicing physician called the State Health Department asking for the toxic ingredient of an ant jelly preparation ingested by a two year old child. The department gave the information that it contained thallium one per cent to the physician before the mother and child had arrived at the doctor's office. The child was trans-

Dr. Tuttle. *Chief of Medical Services, Connecticut State Department of Health*

Mr. Keehn. *Director of Vital Statistics, Connecticut State Department of Health, Hartford, Connecticut*

ferred to the hospital at once and proper treatment given.

Item 5. The Food and Drug Administration recently investigated a death reportedly caused by paraldehyde but found that this death was actually due to acetic acid. Paraldehyde, when stored for a long time in a partially filled container, can break down to acetic acid. The U.S.P. monograph on the drug suggests that paraldehyde should be kept in a well filled, light-resistant, tightly closed container which holds not more than 120 Gm., preferably at a temperature about 30 degrees C. This fact should be kept in mind when dealing with an "atypical" case of paraldehyde poisoning.

Accidental poisonings constitute a significant problem facing the medical profession today. The uncertainties of "How much did this child or adult ingest?" and "How long has it been since ingestion?"—these are in themselves difficult questions.

The worst problem, however, centers around the lack of information and knowledge about the suspected material. "What is the toxic ingredient and how toxic is it?" is what causes the frustration among the physicians.

There are approximately 14,000 accidental deaths reported annually in this nation among children one to fourteen years of age. Of the 14,000 almost 1,500 are reported as being caused by accidental ingestion of poison. This number is undoubtedly much too low, because some studies have reported 25 per cent

of accidental deaths are due to poisoning. Reliable estimates are that for each death there are at least 150 nonfatal accidents, and of the 150 about 6 result in some permanent disability. In Connecticut in 1956 there were 28 deaths and an estimated 6,000 nonfatal accidental poisonings.

An impressive finding in the New Bedford Accident Prevention program was that all but one per cent of home accidents in childhood were preventable.

Increasing use of chemical products in industry, agriculture, and the household makes it important that physicians be familiar with types of poisoning that can occur and with toxic ingredients in so-called trade-name products.

GROWTH AND DEVELOPMENT OF POISON INFORMATION CENTERS IN THE UNITED STATES

The first poison information center was established in Chicago in 1953 because of the interest of the American Academy of Pediatrics in preventing accidental poisoning among children by helping the physicians cope with the rising rate and increasing complexity of cases of accidental poisonings.

Since 1953 the number of centers in the United States has increased rapidly and by November, 1956 there were 44 centers in 18 states throughout the country. As of September, 1957, it is estimated that there are about 102 centers in 36 states throughout the country.

The majority of the 102 centers are independent local operations. Those integrating at a state level are in Florida, Massachusetts, New York, Oklahoma, and Connecticut. The latter state is the only one operating under legislative authority for a State Information Center.

NATIONAL CLEARINGHOUSE

In 1957 the Department of Health, Education, and Welfare established in its Public Health Service a national clearinghouse for poison control centers at the request of the American Academy of Pediatrics and the Public Health Association. The purposes of the clearinghouse are:

1. Interchange of information with local poison control (information) centers throughout the country.
2. Stimulation of development of new or improved methods of prevention and treatment of poison cases, and encouragement of research, both basic and clinical.

3. Aid to states and local communities in establishing poison control centers.
4. Study of national and area trends in poisoning and successful methods of prevention and treatment.

DEVELOPMENT OF STATE POISON INFORMATION CENTER IN CONNECTICUT

On October 26, 1956 a Poison Information Advisory Committee was appointed by Stanley H. Osborn, M.D., commissioner of health, from representatives of the following agencies and organizations to study the establishment of a Poison Information Center:

Connecticut Hospital Association; Connecticut Chapter, American Academy of Pediatrics; Food and Drug Commission; Pharmacy Commission; Connecticut State Medical Society; Committee on Food, Drugs, and Cosmetics, Connecticut Agricultural Experiment Station; existing Poison Information Centers: (Stamford Hospital, Torrington Hospital); and Connecticut State Department of Health.

This committee submitted comments and aided in drawing up the proposed legislation, "An Act Concerning the Establishment of a State Poison Information Center," which became Senate Bill 194, and was signed by Governor Ribicoff on May 29, 1957 and became Public Act 583.

PUBLIC ACT NO. 583 (1957), STATE OF CONNECTICUT

Section 1. The state department of health shall establish and maintain within the department a poison information center for the collection, exchange and dissemination of information needed to minimize damage from potentially toxic substances. The commissioner of health, with the advice and consent of the public health council, shall appoint a director of such poison information center who shall perform the duties of his office under the direction and control of said commissioner.

Sec. 2. The poison information center shall: (a) establish and maintain a file on the general composition of substances which, if ingested, inhaled or applied topically to any part of the body, would cause concern for possible toxic reactions; (b) establish and maintain a file on potentially toxic substances including physiological effects of the toxic substance, the symptoms and signs of toxic reactions and specific antidotes, if any; (c) establish and maintain a file or library of reference material on toxicology, and (d) disseminate information contained in subsections (a) and (b) to hospitals in the state which establish regional information centers.

through duplicate index sets and periodic bulletins. Information in the indexes and reference material shall be provided on request according to policy established by the state department of health, and if the requested information is not available in the state center or regional centers, appropriate steps shall be taken to locate the information desired. Said center shall utilize its resources and information to reduce the incidence of accidental poisonings in the state. The state department of health may develop forms and methods for collecting additional information and require such reports as may be necessary to the discharge of responsibilities of the center.

Sec. 3. The sum of thirty-eight thousand two hundred dollars is appropriated to carry out the purposes of this act.

Sec. 4. This act shall take effect from its passage.

STATE CENTER FUNCTIONS

The State Poison Information Center is the nerve center of the program. The center is organized as a unit to serve the hospital poison control services by assembling and distributing information on toxic substances essential to prompt and proper treatment of the poison victim. The state center will provide consultation and guidance to participating hospitals on organization and operation and will by continued evaluation of the problem of poisoning, strive to minimize its seriousness. The state center will also give continuing attention to the development and implementation of more effective methods of reducing the incidence of accidental poisoning by working with state and local official or voluntary agencies.

The state center is not designed to provide routine telephone information service to physicians, but will operate on a 24 hour basis to locate and provide information on toxic substances not listed in the files of the participating hospitals in the program.

HOSPITAL POISON CONTROL SERVICES

The participating hospital is geared to the emergency situation by providing a poison information and treatment facility which will be readily available at all times. It should be prepared to respond to the physician's phone call for information on the presence of harmful ingredients in some preparation or product involved in a particular case of possible poisoning. The participating hospital should be able to provide the physician with information concerning the toxicity of poisonous substances, their modes

of action, the signs and symptoms of toxic reactions to look for. If specific antidotes are known, the physician should be informed of these together with notes on treatment indicated and contra-indicated for the substance involved.

The poison control service should be properly equipped to provide emergency treatment for cases brought to the hospital.

It is not, however, intended to relieve the physician of the responsibility for professional care of the patient, but rather to function in the manner of the hospital's emergency facility.

The organization and method of operation of each hospital poison control service will be the responsibility of the participating hospital and its staff. As the program develops each such hospital may eventually function as follows:

1. Maintain a 24 hour emergency treatment service.
2. Maintain a 24 hour telephone answering service for the purpose of providing information to physicians and hospitals on the toxic nature of substances.
3. Maintain basic reference materials and current information organized for rapid entry on identification and treatment of poisonings.
4. Conduct staff programs.
5. Participate with the State Department of Health, local health departments and other voluntary or official agencies in a public education program for the prevention of poisonings.
6. Cooperate with the state center in a continuing evaluation of the state and community poisoning problem, including preparing reports of cases treated and telephone calls received requesting information on poisoning.

POISON INFORMATION FILES

The state center is responsible for providing hospital poison control services with reference files and materials to aid in the identification of toxic substances involved in potential poisonings and treatment notes for specific toxic substances. These reference files and materials will be assembled by the state center through exchange of information with the National Clearing House established by the U. S. Public Health Service, through correspondence with manufacturers and through library research. The basic files which will first be assembled are:

1. A file for the identification of the poisonous components of substances which if ingested, in-

haled or applied topically to the body, would cause concern for possible toxic reactions. This file will be referred to as the "A" file.

2. A file of notes by specific poisons on the action of the toxic substances on the individual, the signs and symptoms of toxic reactions and treatment notes including specific antidotes, if any. This file will be referred to as the "B" file.

"A" file

The "A" file will consist of a set of 5×8 cards. These cards will provide for each substance or trade name product which could be suspected of being toxic, the components of the substance, the name and address of the manufacturer. Interfiled with the alphabetic file of substances or products will be the "Type of Product" cards which will list the usual components of each kind of preparation. The type of product card would be referred to when the preparation involved in a possible poisoning cannot be specifically identified by name.

"B" file

The "B" file is designed for reference when potentially toxic ingredients have been identified. This file will consist of a set of 5×8 cards which will be filed alphabetically according to the chemical names of ingredients. The information contained on the card will include toxicity, mode of action, signs and symptoms of toxic reactions, treatment notes, contra-indications in treatment and references to more detailed information concerning the substance.

CONSULTANT FILES

The state center will have an index of consultants in various fields who may be referred to in emergency. These indexes will list under broad headings, i.e., Gardening, Drugs, Hardware, Insects, Plants, Novelties, those persons who have consented to assist the state center on a consultant basis. The hospital poison control services may develop in so far as possible their own consultant files with advice and assistance from the state center.

Each center, state and regional, will have an index of consultants in various fields who may be

referred to in emergency. These indexes will list under broad headings, i.e., Gardening, Drugs, Hardware, Insects, Plants, Novelties, those persons who have consented to assist the center on a consultant basis. Since consultants will be recruited insofar as is possible from the locality of the center, the regional centers will be responsible for developing their own consultant files with advice and assistance from the state center.

IDENTIFICATION OF UNKNOWN SUBSTANCES

The identification of unknown substances involved in potential poison cases often presents a problem. The hospital pathologists offer a solution by providing analytical services for the identification of toxic substances.

The facilities of the toxicological laboratory of the State Department of Health are, as they have been, available upon referral by the pathologist.

Another possible method would be the development of a symptom file which would enable a tentative identification of the substances involved from the combination of characteristic signs and symptoms observed.

OBJECTIVE

The Connecticut Poison Information Program will keep pace with the deluge of new products and will collect, classify and provide information relative to the thousands of real or potentially toxic agents. It is expected that with:

The adequate labeling and packaging of all household chemicals, and

The education of the general public regarding the nature of these hazardous substances, and

The safe use and proper storage of all nonfood substances, and

The prompt diagnosis and adequate treatment of all cases of poisoning, the statewide Connecticut Poison Information Program will help:

Reduce mortality from poisoning.

Reduce morbidity from poisoning.

Reduce anxiety in patients and their families.

Reduce frustrations in physicians and improve medical services.

THE SURGICAL MANAGEMENT OF ULCERATIVE COLITIS

PAUL NEMIR, JR., M.D., *Philadelphia, Pennsylvania*

THE gradual evolution of the surgical treatment of patients with ulcerative colitis has been one of the most satisfactory and gratifying trends in this area of surgery. There is at the present time general standardization of surgical treatment. This evolution may be even more forcefully demonstrated by pointing out that prior to approximately ten years ago we had felt that almost anything in the way of delay, risks, and complications in this disease was acceptable, since ileostomy in its making and management was such an undesirable misfortune that all of the hazards and the high mortality of around 20 per cent were worth accepting to avoid it entirely or to put it off for the longest possible period of time. The difficulties were two-fold primarily. The making of the ileostomy and its subsequent management was a major problem. Prolapse was a severe complication but even more important was that of retraction of the ileostomy into the abdomen as a result of the ileostomy digesting away from the abdominal wall. Management of the resultant ileostomy with its liquid discharges, bad odor, and skin irritations was difficult.

The second major difficulty was that relating to the importance of removing the diseased segment at the time of initial surgery. The procedures generally employed in the past were ileostomy, followed later by subtotal colectomy, and then followed by abdominoperineal resection of the rectum when indicated. Even in the best of hands, the mortality of the operation for subtotal colectomy during this period was in the range of ten to twelve per cent.¹ As our experience has increased in the surgical treatment of ulcerative colitis, the surgical procedures carried out have become more uniform. Experience has shown clearly that our mistakes in the past were due to overconservatism: i.e., trying to preserve involved bowel. It was steadfastly hoped

The Author: *Associate Professor of Surgery, University of Pennsylvania Graduate School of Medicine; Surgeon, University of Pennsylvania Graduate Hospital, Philadelphia, Pennsylvania*

SUMMARY

Surgical treatment of patients with ulcerative colitis is now standardized. Six particular situations are reviewed in which surgery is indicated in ulcerative colitis. The author offers a few comments on the complications of ileostomy.

that the diseased process would subside and that continuity of the gastrointestinal tract could be re-established. With this conservatism, however, the colitis steadily progressed and a malignancy appeared in the diverted colon or in the remaining rectal segment. Whereas in the past transverse colostomies were done for primarily left-sided disease, this unwise procedure is no longer done. Another phase of the conservatism was in attempting to reunite the ileostomy with the remaining rectosigmoidal segment, but again this was demonstrated to be unwise.

Surgical procedures have in the past been further divided into those which were used in emergency situations such as fulminating ulcerative colitis, hemorrhage, perforation or obstruction, and then those procedures which were employed as an elective operation. For example, in the acute fulminating type an ileostomy alone was carried out, or in the perforating type of lesion an ileostomy and drainage of the perforated area was done.

In recent years, however, with improvements in preoperative preparation, management of the ileostomy, maintenance of electrolyte balance, blood replacement, and anesthetic management, the opera-

Read before the 165th Annual Meeting of the Connecticut State Medical Society in East Hartford, Connecticut on May 2, 1957

From the Department of Surgery of the Hospital of the Graduate School of Medicine, University of Pennsylvania, Philadelphia

December, 1957

tive procedures have become uniform whether operating as an emergency or as an elective procedure: namely, subtotal colectomy and ileostomy at the initial procedure followed in around three months by the abdominoperineal resection. This method of management has proved imminently satisfactory. It is necessary to mention at once that there is probably no other area in the entire field of medicine where complete cooperation between the internist and the surgeon is so important as in the management of ulcerative colitis.

It is the purpose of this paper to review those various situations in which surgery is indicated in ulcerative colitis and to discuss in more detail certain aspects of the problem from the surgical standpoint.

1. CHRONIC IDEOPATHIC ULCERATIVE COLITIS INTRACTABLE TO MEDICAL REGIMEN

This forms the greatest segment of the surgical cases. Preoperatively, it is important in these patients to correct a blood volume deficit which is almost invariably present. Maintenance of the electrolyte equilibrium and replacement of protein losses is also an integral part of the treatment preoperatively. At operation these patients are generally not good risks and every effort is made to facilitate the procedure. The procedure routinely carried out by us is that of subtotal colectomy with ileostomy at the first operation. Our policy is to fashion the ileostomy stoma initially and then to remove the colon around to the sigmoid. Our purpose in doing this is that should the patient's condition suddenly deteriorate on the table, then we may stop at any time after the ileostomy stoma has been fashioned. Actually, due to the contracture of the flexures, the colon may be removed very rapidly. The sigmoid colon is then brought out as a mucous fistula at the lower end of the incision. Our present policy is to place a plastic ileostomy bag on the ileostomy immediately after operation. In this fashion, all of the ileal contents are immediately collected in the bag and the skin irritation is kept at an absolute minimum. This has proved to be a very satisfactory way of handling the ileostomy stoma and, in addition, it may be inspected at all times through the plastic bag. These plastic bags are changed daily or as necessary and between eight to fourteen days a permanent type of appliance such as a Rutzen bag is fitted.

At the time of operation the distal ileum may be involved, if not grossly, then microscopically. Our

policy has been to resect the distal eight to twelve inches of ileum and immediately to send to the pathologist a segment of the wall of the ileum at the level of the cut end so that a frozen section may be carried out. If there is evidence of involvement at this level, then more of the ileum is removed.

Generally, the ileostomy will begin working around the third day and it is extremely important to carefully follow the patient's fluid equilibrium at this point, since electrolyte imbalance may occur as the result of losses of large quantities of drainage from the ileostomy.

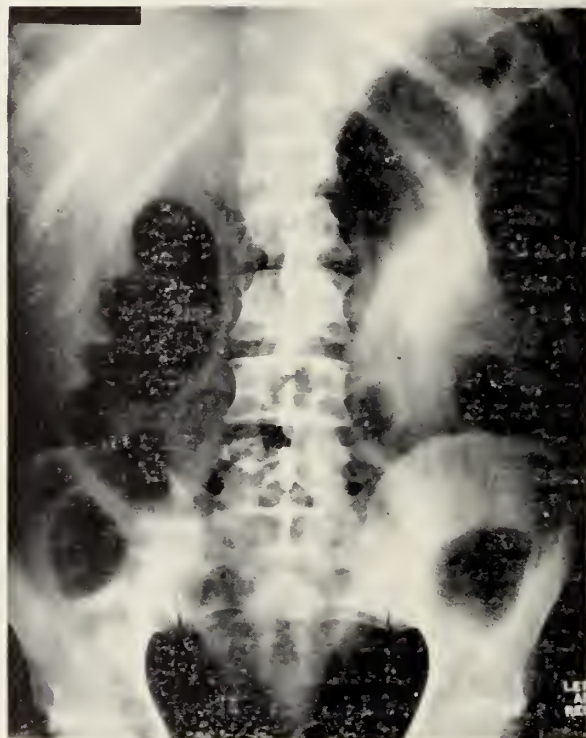


FIGURE 1

Survey film of abdomen of 63 year old male with acute fulminating ulcerative colitis. The extreme distention of the entire colon is a characteristic finding. Perforation is an ever present danger and, if walled off, may be extremely difficult to diagnose in the face of the extreme distention. Increasing abdominal tenderness is one of the most reliable signs of perforation under such circumstances.

Our policy has been to have the patient return to the hospital between three and six months for removal of the rectum and remaining sigmoid. Of course, should the patient have difficulty from the retained segment, then removal is carried out at an earlier time. We have found that by this method

of management our patients have done extremely well. It is indeed gratifying to see how satisfactorily they adjust to the ileostomy.

2. ACUTE FULMINATING ULCERATIVE COLITIS

INTRACTABLE TO CONSERVATIVE MANAGEMENT

Another indication for surgery is that of acute fulminating ulcerative colitis which does not respond to conservative measures. These patients are usually extremely ill with much abdominal distention, high fever, tachycardia and severe electrolyte imbalance. If, in spite of intensive conservative management the vital signs do not improve and the distention appears to be increasing, operative intervention is indicated. Perforation of the acutely distended loops of bowel is a real hazard and it may be very difficult at times to tell when this complication has occurred (Figure 1). At operation, the procedure is essentially the same as that carried out in an elective procedure: namely, ileostomy and subtotal colectomy. We no longer perform an ileostomy alone when operating upon the acute fulminating variety of the disease. We feel that it is far better to remove the diseased colon at the initial procedure even though it may slightly prolong the operation. With our present methods of supportive therapy there have been no instances of a mortality as a result of utilizing this more extensive procedure. Moreover, the patient's general condition begins to improve almost immediately, once the diseased colon has been removed.

3. HEMORRHAGE

Another indication for surgery in ulcerative colitis is in the treatment of the complications. Hemorrhage is a complication which may necessitate immediate surgical intervention. While hemoglobin losses may generally be satisfactorily maintained with transfusions, exsanguinating hemorrhage may occur. We have had instances in which exsanguinating hemorrhage occurred from the remaining rectosigmoidal segment following subtotal colectomy and ileostomy. Under these circumstances, emergency abdominoperineal resection has been carried out.

4. PERFORATION OF THE COLON

Perforation of the colon is one of the most serious complications of ulcerative colitis. It has been associated with an extremely high mortality in the past because it is impossible to close the defect in the friable diseased colon and even when it is closed and the fecal stream diverted by ileostomy, the in-

volved bowel continues to act as a focus of infection and death may occur from peritonitis.

Although we have only very rarely seen perforation, its incidence has been reported as high as 8 per cent in some series of ulcerative colitis. It occurs most frequently in acute fulminating ulcerative colitis. Perforations have occurred concomitantly with the use of Cortisone in the acute fulminating disease and it is for this reason that great care must be exercised in the use of this drug in the treatment of the fulminating variety.

The diagnosis of perforation is easy if there is free communication with the peritoneal cavity. In such cases obvious peritonitis is present with abdominal rigidity and obliteration of liver dullness. Free air is usually demonstrable on roentgenologic examination. It is more difficult to diagnose an impending or walled-off perforation in a patient acutely ill with ulcerative colitis. Abdominal tenderness is usually present but any increase in tenderness or rigidity is of serious significance. The presence of a greatly distended loop of colon seen on a survey film of the abdomen is a warning sign of impending perforation.

In these cases an ileostomy and subtotal colectomy should be carried out. This procedure is entirely logical, since it removes an essentially gangrenous organ which has perforated, causing peritonitis.

The diagnosis of perforation should be borne in mind whenever there is a decided increase in abdominal tenderness or when roentgenograms reveal the presence of greatly distended loops.

5. OBSTRUCTION AND STENOSIS

Another complication of ulcerative colitis which may require operative intervention is that of obstruction and stenosis. Segmental areas of stricture and narrowing are not infrequently encountered in the course of the disease and since the pathologic process is essentially irreversible, nothing short of surgery will relieve the obstructive process. Here again, the definitive procedure of ileostomy and subtotal colectomy followed later by abdominoperineal resection is the procedure of choice.

6. MALIGNANT DEGENERATION

A sixth complication necessitating surgical intervention is that of malignant degeneration. There can be little doubt that the incidence of carcinoma in ulcerative colitis is higher than that in the normal population, probably being somewhere between two and four per cent as compared to an incidence of

colon carcinoma of 0.02 per cent in the normal population. The incidence of carcinoma in long standing ulcerative colitis is even greater.

When colonic carcinoma develops in ulcerative colitis, it has been found universally that the disease is extremely malignant and runs a very rapid course. This is probably due to two factors. One is the high grade of malignancy not infrequently seen with inflammation: for example, inflammatory carcinoma of the breast; and a second factor is the difficulty in diagnosis.

The pathogenesis of carcinoma in ulcerative colitis continues to be a controversial issue. Some have felt that the pseudo polyps or inflammatory polyps are changed to true adenomatous polyps and then to carcinoma. It is probable, as Gelber, Hawthorne, and Gelb² of our institution have pointed out, that the pseudo polyps are not disposed to cancer formation but that cancer develops from pre-existing adenomatous polyps or from foci of regenerative epithelial hyperplasia. Actually the pseudo polyps are areas of mucosa between the diffused ulcerative process. There is no active proliferation. It is more likely that the intense destruction of the mucosa with just as intense an attempt at repair may be responsible for the proliferative process. Thus, the burned out areas with very reactive repair may develop a malignancy in much the same manner in which carcinoma develops in a burn scar.

The validity of this concept is further borne out by the gross appearance of carcinoma in ulcerative colitis. There is not the well defined, short, scirrhous lesion commonly seen. Instead, these are infiltrating scirrhous lesions of indefinite ill defined boundaries situated in areas showing smooth fibrous tissue and presenting a burned out appearance.

It would seem to us that once intractability has been established, complete colectomy will reduce the incidence of these very malignant carcinomas.

COMPLICATIONS OF ILEOSTOMY

Almost universally, the complication of postoperative intestinal obstruction or complications of the ileal stoma are high. Intestinal obstruction postoperatively occurs in around forty per cent of the patients, but fortunately is usually relieved with long tube decompression (Figure 2). Reoperation, however, may be necessary in approximately ten per cent of the patients having this complication. It is our policy to pass a long intestinal tube of the Miller-Abbot or Kantor type if obstructive symptoms develop and then to carefully follow the



FIGURE 2

Survey film of abdomen showing postoperative intestinal obstruction following ileostomy and subtotal colectomy. A long intestinal tube is passed when signs of obstruction develop and the patient is carefully followed with serial roentgenograms. In this instance decompression was successfully accomplished with the long tube. The ring of the plastic ileostomy bag is shown in the right lower quadrant of the abdomen. Occasionally a kink may be present just proximal to the ileostomy stoma. A soft rubber catheter gently passed through the ileostomy may be successful in relieving the obstruction.

patient with serial roentgenograms at eight to twelve hour intervals. Should there be evidence that the condition is progressing, then operative intervention is carried out without delay.

Prolapse, retraction, or fistulae formation about the ileal stoma occurs in ten to fifteen per cent of the cases but I think it is important to stress that these complications are either minor or of a corrective nature and they in no manner obviate the excellent results obtained with ileostomy and colectomy.

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*A worthwhile method of clearing up
skin lesions in infants*

TOPICAL THERAPY AND PROPHYLAXIS IN DERMATOSES OF INFANCY AND CHILDHOOD

LEO LITTER, M.D., *Hartford*

THE purpose of these studies was to determine the value of the everyday use of Caldesene* for the prophylaxis and treatment of diaper rash, sudamina, and allied dermatoses in infants and children.

Minor skin lesions are usually self limited, and respond favorably to application of a bland oil or lotion. However, the more significant and extensive skin eruptions and infections are more resistant to ordinary measures. The use of ammoniated mercury, sulfathiazole cream, or antibiotic ointments has been discarded by many because of the high incidence of secondary dermatitis and sensitivity. Hence, it is important to determine if any prophylactic or therapeutic measure can be employed to reduce the occurrence of these lesions. This study was, therefore, undertaken to determine the effectiveness of a powder containing 15 per cent calcium undecylenate in a 3 per cent boric acid neutralized talc base in the prophylaxis and treatment of common dermatoses in infancy and in early childhood.

One hundred infants and children with varying degrees of diaper rash, intertriginous eczema, and other irritations of the skin were treated with Caldesene. Cultures were taken and examined carefully in the microbiological laboratories of Wallace and Tiernan at Belleville, New Jersey.

SUCCESS OF CALDESENE

There were 43 males and 57 females, of whom 96 were white and 4 were negroes. The ages ranged from one month to five years. The skin lesions treated included diaper rash, impetigo, intertrigi-

The Author, *Assistant in Epidemiology, McCook Memorial Hospital; Assistant in Pediatrics, Mt. Sinai Hospital, Hartford, Connecticut*

SUMMARY

One hundred infants and children with various types of skin conditions were treated with Caldesene. Improvement was far greater when bacteria were the etiologic factor than when yeast organisms were the causative agent.

In the control group, the skin irritations lasted two to three times longer than in the Caldesene treated group.

Caldesene, a formulation containing 15 per cent calcium undecylenate in a neutralized talc base, possesses a number of physical properties especially advantageous in the treatment of diaper rash, chafing, and prickly heat.

nous eczema, pyoderma, tinea circinata, and seborrheic dermatitis.

Caldesene was prescribed. Many cases cleared up dramatically after only a few days' treatment; others necessitated a little longer therapy.

It was gratifying to note the enthusiasm of the mothers even after they had used Caldesene only a few days.

Interesting was the amount and frequency of improvement obtained when the etiologic organisms were predominantly bacteria, including the urea-splitting bacteria. In 38 such cases (see Table I), the improvement was excellent in 16, moderate in 18 cases, and slight in 4 cases. To a lesser extent,

*Caldesene was supplied by Maltbie Laboratories Division, Wallace and Tiernan, Inc.

but still very impressive, were the results obtained when yeast organisms were found on the cultures.

TABLE I
EVALUATION OF CALDESENE IN 100 CASES OF DIAPER RASH

MICRO-ORGANISM	NO. OF CASES	IMPROVEMENT			
		EXCELLENT	MODERATE	SLIGHT	NONE
Bacteria	38	16	18	4	—
Fungus contaminate (Fungus <i>Aspergillus</i> <i>niger</i>) 2 cases	8	1	4	3	—
Yeast					
<i>Candida albicans</i>	6	2	4	—	—
Not <i>Candida albicans</i>	45	17	22	4	2
<i>C. Parakreusi</i>	1	—	1	—	—
No growth (tube broken in one case)	2	1	1	—	—
Total	100	37	50	11	2

In one group of 45 cases, where noncandida albicans yeast organisms were found, excellent improvement was found in 17 instances, moderate improvement in 22, and 4 showed slight improvement.

This was a controlled study. Another group of one hundred infants and children was treated simply with cornstarch or a bland baby powder (not antimicrobial). In the control group the diaper rash lasted two to three times longer, and 30 per cent more pyogenic infections were seen than in the Caldesene treated group.

WHAT IS DIAPER RASH?

Diaper rash is an erythematous and desquamating eruption which is found in varying degree as a result of decomposition of urine with liberation of ammonia. The condition is generally confined to the "diaper" area, though any part in prolonged contact with such chemically modified urine may be affected, that is, heels and legs. The primary cause of the condition lies in a lower bowel bacterial contaminant (*B. ammoniagenes*) which reacts with the urea in the urine to liberate ammonia. Strongly alkaline soaps and active domestic detergents, often accompanied by inadequate rinsing of napkins, provide contributory causes. The condition is commoner in bottle-fed babies. It may be associated with, or produce, eczema elsewhere. Sequelae of the initial erythema are found in papular and necrotic lesions, conditions assuming more menacing characteristics.

DETAILS OF TREATMENT

The diapers should be adequately washed and rinsed in ammonia-inhibiting preparations with immediate drying. This inhibits the bacterial action. Frequent changing of diapers is essential. Modification of carbohydrate intake may discourage the growth of the bacteria in the bowel.

SUDAMINA AND ITS TREATMENT

Sudamina is an irritating eruption identical with "prickly heat" and is quite common in infants. Unsuitable, close-knit and moisture-retaining underclothing is primarily provocative. The rash is widespread and is seen as minute pinhead-sized vesicles, usually containing clear or slightly milky fluid with occasional pustules. Diffuse erythema is common. Any febrile illness accompanied by sweating provides the basic etiological factor.

Simple dusting powder, daily bathing in weak antiseptic solutions, avoidance of wool, light bedding and a cool atmosphere bring rapid clearance.

PROPERTIES OF CALDESENE

Caldesene has a beneficial healing influence upon diaper rash and minor skin irritations. It promotes swift reduction of erythema, scaling and healing of diaper dermatitis.

Caldesene is a reliable nonirritating, nonsensitizing antimicrobial which inhibits infection. Because of its bacteriostatic action, it is also effective in some dermatoses complicated by impetiginous infection. These properties have been clinically established. This powder is readily tolerated, safe, nonirritating and nontoxic. Sensitization to it is uncommon. It is designed for general care of the infant's skin and is effective in a wide range of infants' common skin disorders. It is nonstaining and is recommended for the tender and sensitive skin of babies when an emollient and protective action is desirable.

CONCLUSIONS

From a series as small as this, it was not possible to make any statistical analysis, but some general impressions were obtained.

Caldesene is a useful adjunct for routine therapeutic use and for prophylactic aid in infants and children subject to: ammoniacal dermatitis, impetiginous eczema, intertrigo, pyoderma, seborrheic dermatitis, tinea and yeast organisms.

*Here are reports of two drugs
which are helpful but must be
used with caution.*

EMOTIONAL DISORDERS TREATED WITH MEPROBROMATE AND PROMAZINE

PAUL N. GRAFFAGNINO, M.D., PATRICK B. FRIEL, M.D. and WILLIAM W. ZELLER, M.D., *Hartford*

THE present paper is a sequel to a recent report entitled "New Drugs in the Treatment of Emotional Disorders: A Review."¹ It presents a clinical study on two of the newer ataractic drugs referred to in the original review. The purpose of the current study is to determine the value and effectiveness of promazine (10-(*g*-dimethylamino-*n*-propyl)-phenothiazine hydrochloride) and meprobamate (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) in the treatment of various emotional disorders.

Promazine has the same structural formula as chlorpromazine (10-(3-dimethylaminopropyl)-2-chlorphenothiazine hydrochloride) except for the removal of a chlorine radical from the phenothiazine structure. Meprobamate was developed from mephesisin (3-(ortho-toloxyl)-1,2-propanediol). It was synthesized in 1950 as one of a number of aliphatic derivatives of mephesisin. Meprobamate was found to have a pronounced muscle relaxant effect, a considerable anticonvulsant action, and also a noticeable taming effect on monkeys. In man it was found to have the additional property of relieving tension and anxiety.

Since the writing of the review article mentioned above, promazine has become an established agent in the management of acute psychiatric disturbances.^{2,3,4,5,11} It would seem that promazine is as effective in the management of acutely disturbed patients as is chlorpromazine, and it has the desirable advantage of being less toxic. The use of promazine in the management of chronic emotional disturbances has not been reported as fully.

Many studies have also been reported on mepro-

Dr. Graffagnino. *Staff psychiatrist*

Dr. Friel. *Staff psychiatrist*

Dr. Zeller. *Associate Director of Psychiatric Education and Coordinator of Clinical Research, Institute of Living, Hartford, Connecticut*

SUMMARY

This study was undertaken to evaluate the effectiveness of two of the newer tranquilizing agents, promazine and meprobamate, in the management of emotional disorders among hospitalized psychiatric patients. These illnesses ranged in severity from neurotic to psychotic disturbances and included organic brain syndromes. Multiple independent clinical observations were made by physicians and nurses using specially designed rating scales. Both drugs were found helpful in relieving certain symptoms such as anxiety, tension, agitation and insomnia. In general, promazine is more effective in controlling psychotic behavioral disturbances whereas meprobamate is more effective in alleviating symptoms of anxiety tension states. Meprobamate was found to have a specific soporific action. Both drugs were effective in controlling the symptoms of alcohol and narcotic withdrawal. Neither drug was found to have any particular value in the treatment of depressed states. These medications, like other tranquilizers, are not panaceas for emotional illnesses. Their main benefit is as an adjunct to other established psychotherapeutic procedures. Both drugs were found to have toxic reactions and side effects and therefore should be administered with caution and adequate medical supervision.

Meprobamate (Equanil) and promazine (Sparine) were supplied through the courtesy of the WYETH Laboratories.

bamate since publication of the initial review.^{1,12,13,14} Most of these reports dealt with the treatment of outpatients rather than hospitalized patients. Mepro-

bamate is indicated for the control of symptoms of tension, tension headaches, anxiety, and insomnia. Although earlier reports seem to indicate that the use of meprobamate did not lead to habituation, recent evidence indicates that there may be a tendency for patients to become psychologically and possibly physiologically dependent on it.⁹ There are reports of grand mal convulsions occurring after discontinuation of meprobamate in some patients.¹⁰

The patients in the present study were under treatment in a private psychiatric hospital. The severity of their illnesses ranged from neurotic disturbances to severe psychotic disturbances and also included organic brain disease. This group includes those patients who showed more protracted and chronic emotional disturbances.

It was also part of the initial plan to determine by the administration of placebo medication whether or not the drugs were responsible for the clinical improvements observed in the patients. However, this part of the study could not be accomplished with regard to meprobamate because it became apparent soon after the study began that the patients were able to detect the difference in taste between the placebo and the meprobamate tablets. Meprobamate tablets have a characteristic and unique bitterness which could not be duplicated by placebos. The reactions of many of the patients to these variations in taste were so pronounced as to throw into serious question the validity of the placebo study. There was no such problem, however, with the promazine placebos, and this part of the study will be reported.

METHOD OF STUDY

Thirteen patients treated with promazine comprised an experimental group in which a two to four week trial of placebo medication was instituted. These patients were thoroughly studied and were used as their own control in evaluating placebo effect. No one having clinical contact with the patients knew when the administration of placebos was instituted. The institution of placebos was under the control of an independent agent who had no communication with the authors or any of the other investigators having clinical contact with the patients. He selected both the patients and the date of institution of placebos by use of random tables.

Multiple, independent, clinical observations were made by each patient's psychiatrist, members of the

nursing staff, and members of the department of occupational and educational therapy. These observations were reported at daily staff meetings. Each week the physician and the nurse in charge of the patient filled out a special report in which the patient's clinical progress was rated according to selected items of a revised rating scale developed by Zeller and Resznikoff.¹⁶ This special report also included such items as dosage, mode of administration, toxic effects and side reactions, the use of electroshock, insulin therapy, hydrotherapy, cold wet packs, and any moves that the patient made in terms of advancement to more convalescent or return to more disturbed units. At the end of each week all such reported information was recorded on a detailed summary sheet. From this summary sheet response or lack of response in each of the three spheres of personality functioning, namely, ideation, affect, and behavior, was recorded. Improvement was rated as none, slight, moderate or pronounced. No promazine-treated patients were included in this study who received the drug for less than four weeks. All patients in the meprobamate study had received the drug for at least two weeks. In both groups many of the patients received the drug without interruption over a period of six months. Adequate recommended doses were administered. Average dosage for promazine was approximately 400 mgs. per day (range 100 mgs. to 1200 mgs.). For meprobamate the average dosage was 1600 mgs. to 3200 mgs. per day (range 800 mgs. to 6400 mgs.). Most of the promazine was given orally, although parenteral administration was used for acutely disturbed and agitated patients. All of the meprobamate doses were given orally.

RESULTS OF STUDY

A. PROMAZINE

Tables I and II indicate the clinical results obtained in the treatment of ninety-three patients of various diagnostic categories. It will be noted that these ninety-three patients carried one hundred five diagnostic labels, since many of those included under the group of acute toxic states showed a definite underlying personality disturbance. The addiction to either drugs or alcohol in these patients was considered to be symptomatic of underlying pathology. Of the sixteen patients in that group, twelve were continued on promazine medication in an effort to effect a change in the underlying personality disturbance.

TABLE I

DIAGNOSIS	NO. OF *DRUG		+NO	SL.	MOD.	PD.
	PATIENTS	USED				
Schizophrenic reactions						
Paranoid	17	P	8	3	6	0
	7	M	5	1	1	0
Acute undiff.	0	P	0	0	0	0
	10	M	2	4	4	0
Chronic undiff.	25	P	10	6	9	0
	28	M	9	4	14	1
Other	10	P	4	3	3	0
	7	M	0	2	5	0
Affective disorders						
Manic	2	P	0	0	1	1
	2	M	0	0	1	1
Psychotic depressions	8	P	1	1	6	0
	37	M	12	11	9	5
Neurotic reactions						
Anxiety	2	P	2	0	0	0
	9	M	1	2	6	0
Depression	1	P	1	0	0	0
	16	M	6	4	4	2
Other	3	P	1	0	2	0
	5	M	3	2	0	0
Character disorders	16	P	14	0	1	1
	15	M	2	3	10	0
Toxic States						
Drugs and alcohol	16	P	0	0	6	10
	4	M	0	0	3	1
Organic states	5	P	2	3	0	0
	5	M	0	2	2	1
Total	105	P	43	16	34	12
	145	M	40	35	59	11

* P = promazine, M = meprobamate, +No = No improvement, SL. = Slight improvement, Mod. = Moderate improvement, Pd. = Pronounced improvement.

Table I shows the general overall improvement obtained in the patients classified into major diagnostic categories. It will be noted that the sixteen patients in the acute toxic category showed the most pronounced improvement. Six are listed as showing moderate and ten as showing pronounced improvement. These results confirm the many reports in the literature of the effectiveness of promazine in withdrawal states.^{2,3,5,11} The other groups showed less dramatic improvement. There were fifty-two chronic schizophrenic patients treated with promazine and the following results were obtained: twenty-two of these showed no response, twelve slight improvement, eighteen moderate improvement, and none pronounced improvement. In the affective group of disorders there were two manic depressive, manic patients. One of these showed a moderate and the other a pronounced improvement. There were eight psychotically de-

pressed patients. Of these, one showed no response, one slight, six moderate, and none pronounced. Of sixteen patients showing character disturbances, fourteen showed no over-all improvement, one moderate, and one pronounced improvement. Five neurotic patients were studied, four of whom showed no response and one moderate improvement. There were five organic states, two showed no response and three slight improvement.

The overall evaluation of the effectiveness of promazine in the management of emotional disorders can be further studied in terms of improvement in ideation, affect, and behavior, as presented in Table II. It will be noted that the improvement was reflected most often in behavior and affect, and only to a minor degree in ideation. Of the eight recorded improvement in ideation, six were in toxic states, one in the manic reaction, and the other in a paranoid schizophrenic reaction. Also it should be emphasized that none of the depressed patients showed improvement in their ideation. Five showed some degree of improvement in their affect, but this improvement was characterized by a decrease in tension and anxiety rather than any alleviation of their despondent mood.

Toxic reactions to promazine were relatively few compared to those seen with chlorpromazine, as previously reported.¹⁵ Five patients had grand mal seizures while on the drug. Drowsiness was reported by four patients, dry mouth by two, weakness in the legs by two, and tremor by one. Syncope occurred four times during the treatment of one patient in whom repeated electrocardiographic and electroencephalographic studies were normal. Nausea, vomiting, and heartburn occurred in combination in one patient. None of the patients treated developed parkinsonism, jaundice, or agranulocytosis. Neither did any patient complaint of sun sensitivity, although a number of those treated with promazine had previously complained of this symptom while under chlorpromazine medication. None of the patients receiving promazine parenterally developed any muscle tenderness, pain, or local skin reaction such as observed in the parenteral use of chlorpromazine. None of the nursing personnel developed contact dermatitis from handling the parenteral preparations. No specific electroencephalographic changes were noted in promazine-treated patients, such as those observed in patients receiving meprobamate. The placebo study was carried out in thirteen patients, eleven of whom showed chronic schizophrenic disturbances. In clinically evaluating

TABLE II

	NO. OF		*DRUG	IDEATION			AFFECT				BEHAVIOR			
				PATIENTS	USED	+NO	SL.	MOD.	PD.	+NO	SL.	MOD.	PD.	+NO
Schizophrenic reactions	52	P	50	1	1	0	38	7	7	0	24	12	14	2
	52	M	49	2	1	0	28	5	18	1	22	10	19	1
Affective disorders														
Manic depressive manic	2	P	1	0	1	0	0	1	1	0	0	0	1	1
	2	M	1	0	0	1	1	0	0	1	1	0	1	0
Psychotic depressions	8	P	8	0	0	0	3	2	3	0	2	1	5	0
(Manic depressive, Depressed; Invol. Psychosis; Psychotic Depressive Reactions)	37	M	36	0	1	0	21	4	8	4	18	6	8	5
Toxic states														
Drugs and alcohol	16	P	11	0	2	3	0	1	6	9	0	1	6	9
	4	M	3	0	1	0	1	0	2	1	1	0	2	1
Neurotic reactions	6	P	6	0	0	0	4	2	0	0	4	0	2	0
	30	M	28	1	0	1	14	7	8	1	14	10	5	1
Organic states	5	P	5	0	0	0	5	0	0	0	2	2	1	0
	5	M	4	0	1	0	4	0	0	1	0	2	2	1
Character disorders	16	P	16	0	0	0	15	0	0	1	14	0	0	2
	15	M	13	1	1	0	6	2	7	0	5	2	8	0
Totals	105	P	97	1	4	3	65	13	17	10	46	16	29	14
	145	M	134	4	5	2	75	18	43	9	61	30	45	9

* P = promazine, M = meprobamate

+No = No improvement, Sl. = Slight improvement, Mod. = Moderate improvement, Pd. = Pronounced improvement

their responses, it was found that one showed a definite exacerbation of symptomatology, two showed slight improvement, and the others showed no appreciable change while on placebo. Detailed statistical scrutiny of the results on the rating scales reported by physicians and nurses did not show significant changes. Neither change from drug to placebo nor from placebo to drug had any immediate effect on behavioral ratings. However, when patients received placebo medication there was a trend toward deterioration in their behavior on rating scale items such as attitudes towards hospital routine and eating patterns. Improvement was observed when drug therapy was reinstituted.

B. MEPROBAMATE

The diagnoses of the patient receiving meprobamate covered a broad range of psychiatric disorders and were representative of the entire population of the hospital. The general distribution of patients by diagnostic categories is represented in Table I. It will be noted that the general category of psychotic depressions in that table includes thirty-seven patients. This category for the purpose of the present study includes patients in the following diag-

nostic groups: involuntional psychotic reactions (twelve patients), psychotic depressive reactions (sixteen patients), manic depressive reactions, depressed type (eight patients), and manic depressive reactions, other (one patient). This category is justified for the purpose of clarity, since detailed study of the individual diagnostic groups shows the distribution of improvement or lack of improvement to be similar in all groups.

Among the fifteen patients in the general category of character disorders, four were diagnosed as emotionally unstable personality, nine were called passive-aggressive personality, and two were diagnosed as schizoid personality.

Table I further shows the general overall improvement of the patients receiving meprobamate. Especially with meprobamate, these figures must be taken as only a gross approximation of the effects of the drug because, as will be discussed below, meprobamate tends to affect only specific symptoms without necessarily having any general effect. Consequently, such a tabulation can give only a limited indication of the effects of the drug. It does show quite definitely the number of

patients who did not receive benefits from the drug. With these reservations in mind then, Table I shows that meprobamate was effective as follows: Of seven paranoid schizophrenic patients, five showed no improvement, and two showed improvement in some degree. The other three categories of schizophrenic reaction (totalling forty-five patients) showed a consistently better percentage of patients with improvement, that is, thirty-four patients showed some improvement and only eleven showed no improvement. The two patients with manic reactions showed some form of improvement. Among the thirty-seven psychotic depressions, twelve patients showed no improvement and twenty-five showed improvement in some area. Among the thirty neurotic patients, ten showed no improvement, whereas twenty showed some improvement while on the drug. Of the fifteen character disorders, only two showed no improvement whatsoever. All of the nine patients under the categories of toxic states and organic states showed some form of improvement.

Table II shows the degree of improvement in the three fundamental aspects of a patient's functioning, that is, the aspects of ideation, affect and behavior. A general perusal of the table shows that in all diagnostic categories meprobamate is more effective in the areas of affect and behavior than in ideation.

It can be seen from Tables I and II that meprobamate has some beneficial effect on selected symptoms in schizophrenic reactions except perhaps the paranoid group. In the psychotic depressions, both affect and behavior show improvement. For example, twenty-five of the thirty-seven depressed patients showed some form of improvement. This improvement was mainly in relieving the symptoms of anxiety, tension and insomnia which accompanied the depressive reaction. Among the nine anxiety reactions, there were strongly positive results in eight patients. Among the character disorders, there was much improvement in effect and behavior. A good effect can be seen in all four cases of alcohol and drug withdrawal.

Some idea of the type of symptoms helped by meprobamate can be obtained from the following figures. Among the one hundred forty-five patients treated with meprobamate, the following instances of improvement in specific symptoms were noted. There were thirty-six patients in whom the sleep pattern was improved. There were thirty patients in whom anxiety was decreased significantly. In

thirty-one instances tension was reduced. In eight patients agitation was helped. There were three instances of relief of gastric distress and two instances of decreased hypochondriasis. Relief was also reported in one instance of neurodermatitis, one of low backache, one of muscular twitching, two of muscle tremor, and one of tightness in the throat.

The side effects among the one hundred forty-five patients were manifest in a total of twenty-nine patients, or approximately 16 per cent. Thirteen of these twenty-nine showed slight transient lethargy or drowsiness. One showed protracted somnolence, two showed ataxia, two showed dryness of the mouth, two showed an inebriated type of reaction following five-tablet doses, two complained of some difficulty in thinking clearly, and one each showed gastric distress, nystagmus, dizziness, blurred vision, and postural hypotension. One patient with a history of previous skin sensitivity developed a pruritic macular rash over the head and neck appearing twenty-four hours after beginning meprobamate therapy and disappearing after the drug was discontinued. In one patient the depressive symptoms were intensified after the drug was started. There were no serious toxic reactions such as jaundice or agranulocytosis in any of the patients. We have seen no evidence thus far of true addiction or of withdrawal convulsions with the use of meprobamate.

Henry, Obrist⁵ and others made a special study of the effects of meprobamate on the electroencephalograms of many of these patients. Although meprobamate had been thought to have little effect on the electroencephalograms, they did find that meprobamate produced a pattern of fast activity. They summarized their results as follows: "Although the site of action of meprobamate is thought to be mainly on thalamic internuncial circuits, we have noted increased rhythmic fast activity in the electroencephalograms. Seventy patients received meprobamate uncomplicated by other drugs known to have electroencephalographic effects; seventy-six per cent of these showed a distinct rhythmic fast activity in the electroencephalograms."

Gordon, Zeller, and Donnelly have made special biochemical studies of the effects of promazine and meprobamate on certain aspects of protein metabolism.⁶ They have observed that promazine significantly lowers the concentration of serum amino acids, whereas meprobamate does not.

WHAT THOSE DRUGS ACCOMPLISH

By studying the results obtained, it becomes apparent that neither of these drugs exerts an influence on all spheres of the personality. They do not alter the basic psychopathology. Therefore, they cannot be expected of themselves to effect a complete cure. They are valuable as adjunctive measures in the overall management of patients with emotional disorders. Both drugs seem to exert their greatest influence in the relief of specific symptoms. For example, promazine is helpful in controlling symptoms of anxiety, tension, agitation, and overactive behavior. Meprobamate helps anxiety, tension and insomnia. Meprobamate has even more of a focal symptomatic effect than promazine, particularly in its use as a soporific. It was, in fact, often selected for this specific purpose by the patients' physicians in this study. In the treatment of depressions, both drugs have limited value. They exert some influence on agitation and insomnia but do not alter the depressive ideation or mood. Meprobamate was selected more frequently in the management of depressed patients because of the frequency with which the phenothiazine derivatives can precipitate or aggravate a depressive illness.

These drugs are most beneficial in the management of acute toxic states and to a somewhat lesser extent in acute emotional disturbances where symptoms of anxiety and tension predominate. Promazine is of greater value than meprobamate in controlling the overactive and often destructive behavior of the acutely disturbed schizophrenic patient. It would not appear to be effective in the treatment of chronic schizophrenic reactions. The present results confirm that meprobamate helps specific symptoms in hospitalized patients in the same manner as previously reported in outpatients.^{12,13}

Despite some similarities in the clinical responses to the two drugs, nonetheless meprobamate and promazine would seem to have fundamentally different modes or sites of action. For instance, meprobamate in animals has an anticonvulsant action, whereas promazine may precipitate convulsions as observed in five of our treated patients. Meprobamate shows rhythmic fast wave activity on the electroencephalogram, whereas promazine does not produce any such specific changes. Further, it has been shown that promazine depresses the level of serum amino acids, whereas meprobamate does not.

There are inherent risks in the use of these drugs. The disadvantages of promazine lie along the lines

of physiological toxicity (convulsions, agranulocytosis, etc.). Other than the reported occurrence of withdrawal convulsions, the disadvantages of meprobamate fall more in the realm of the psychological (habitation, dependence, etc.). Therefore, for various reasons these drugs should be administered under close medical supervision. Any indiscriminate use should be avoided.

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SLEEPING PARTNER

RICHARD GORDON, *London, England*

SURGEONS are traditionally accused by the medical profession of introducing two necessary evils, wound infection and anaesthetists. In the past hundred years both of these have fortunately become less dangerous to human life.

When chloroform was still a novelty and gas a luxury, the anaesthetist was a seedy practitioner, a Coroner's familiar, creeping around hospitals and nursing homes with a rag of lint in one pocket of his coat tail and a bottle of ether in the other. With this equipment he could perform his shaky tricks instantly and anywhere, like a strolling conjurer. The surgeon took the limelight and ninety per cent of the fee; the anaesthetist at his best was only a Jeeves, ready to smooth the surgical progress of his master, to encourage him in clinical distress, and to temper discreetly his surgical enthusiasms. He was a butt for all the surgical fun that battens on blood and sterile towels—how relieved the nurses were when Sir Lancelot's wrath at a moving target was canalized into: "If the patient can keep awake, Mr. Anaesthetist, so can you." From his perch at the head of the table he yawned at weary accounts of forgotten anatomical battles, and he left the hospital by bicycle in the dust of the surgical limousine.

As operations became longer and anaesthetists had more hours of comparative inactivity to meditate over their humility, they invented a scheme to assert their personalities in the operating theatre. The trick was simple: they repudiated the rag-and-bottle, and invented a machine aglitter with chromium plate and taps to administer the anaesthetic for them. At first the surgeons pretended amusement, and made jokes about "The Gas, Fight, and Choke Company." But they were mystified and intimidated, particularly when the anaesthetist strolled away for a cup of coffee and left his patient tranquilly free-wheeling. It had previously been plain to everyone in the theatre that any damn fool with a bottle and a roll of lint could give anaesthetic, but

even the dullest junior probationer could now see that the manipulation of this secret machine needed the fused skills of an engineer, pilot, and safebreaker.

The anaesthetists coolly pressed their advantage. The machines became bigger and more aggressive, forcing the surgeon to operate uncomfortably in the remaining corner of the theatre. Anaesthetists boldly told their own stories across the towel clips, and the daily operating list ended politely with "General Anaesthetic, Dr. Tompkins, please." Surgeons who once began an operation by plunging knife into abdomen with a roar of "Is he asleep, Bill?" waited patiently for permission, with sterile gloves meekly clasped. Afterwards they bowed over the swab bucket, as the anaesthetist neutralized his apparatus with a pair of spanners, and said "Thank you, Dr. Tompkins—a very beautiful anaesthetic. We shall have the pleasure of working together next week, I presume?" Two limousines now left the hospital courtyard together.

When surgeons and anaesthetists reunited after the war they were faced with problems of readjustment as powerful as those of any other long separated couple. The surgeons had seen Army doctors at work with squares of flannel and ether cans, and had learnt so much about lorries, guns, tanks, and radio sets from enthusiastic brother officers that they were no longer frightened of an anaesthetist's civilian equipment. But they were infuriated to find that anaesthetists had assumed the grand simplicity; heavy apparatus was pushed into the theatre sister's store room, and modern anaesthesia conducted with a single syringe.

This concentration in the anaesthetist's armament was permitted by purification of the curare arrow-poison from South America; the Brazilian pigmy blows a curare-tipped dart into his victim before eating him, and the British anaesthetist sticks a curare-filled syringe into his patient before dishing

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December, 1957

him up to the surgeon. But as more and more unwanted side-effects of the arrow poison were discovered, and more and more drugs were invented to counteract them, the anaesthetist's syringes grew into a battery of violent poisons and antidotes.

Today he arrives at the hospital in a van, which contains his assistants and a number of expensive electronic machines to let him know the pulse and blood pressure without having to count them. The

surgeon is allowed to operate as long as his manipulations do not disturb the anaesthesia; to complain that the narcosis is not sufficiently profound is as unthinkable as sending back the specialty at a famous restaurant. Anaesthetists are friendly men, and have no malignancy in their new mastery; every one of them thoughtfully thanks the surgeon at the end of the operation for making, with his skill, their superb anaesthetic necessary.

Hepatic coma if recognized early is reversible.

Watch for early neurological signs.

*Individualize treatment which has been greatly
improved with modern drugs.*

THE CLINICAL APPROACH TO HEPATIC COMA

EMANUEL FRIEDMAN, M.D., *West Haven* and VINCENT A. DELUCA, JR., M.D., *Derby*

Dr. Friedman. *Fellow in Gastroenterology, VA Hospital, West Haven, Connecticut*

Dr. DeLuca. *Assistant Chief of Medicine, Griffin Hospital, Derby, Clinical Instructor, Yale University School of Medicine, New Haven, Connecticut*

SUMMARY

A wide constellation of precipitating factors may produce hepatic coma in patients with any form of liver disease. Early recognition and vigorous therapy are necessary for the salvage of these patients.

In this syndrome understanding the variability and transitory nature of the alterations in state of consciousness and of motor function is important. Certain characteristic findings, such as the "liver flap" must be searched for diligently. Alertness on the

part of the physician in the first stages of the evolution of coma may be lifesaving.

Treatment is individualized, depending upon the underlying disease process and the immediate precipitating cause. Electrolyte fluid and blood replacement may be required as well as antibiotics in the presence of infection. The value of steroids is controversial, but the authors feel that they have a place in the therapy of refractory hepatic coma. Other adjuncts to treatment such as glutamic acid and arginine have not been fully evaluated.

Hepatic coma is a neurological syndrome that is frequently reversible with prompt and vigorous therapy. A clinical approach to the diagnosis and treatment of this disorder with illustrative case reports is presented.

This paper has been reviewed in the Veterans Administration Hospital, West Haven, Connecticut. The statements and conclusions published by the authors are a result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

RECOGNITION of a neurological syndrome in patients with liver disease has become more frequent in recent years.¹ This has resulted in a more intelligent approach and early treatment with a concomitant increase in reversibility of what formerly had been an almost universally fatal disease.² The purpose of this paper is to present a practical clinical approach to the problem with illustrative case reports in which only pertinent findings are described.

The exact pathophysiology of hepatic coma is not yet clearly understood. Pathologically, the only lesion of the central nervous system found to be associated with the syndrome is a hyperplasia of the protoplasmic astrocytes.³ It is not always apparent why some patients develop the syndrome while others do not. However, there is a group of well recognized precipitating factors⁴ (Table I).

TABLE I
PRECIPITATING FACTORS IN HEPATIC COMA

1. Hemorrhage
2. Paracentesis
3. Overwhelming infection
4. Fulminating hepatitis or acute necrosis of the liver
5. Transfusion reactions
6. Oversedation
7. Surgery — trauma.
8. Excessive fluids or dehydration
9. Drug induced
 - A. Diamox
 - B. Ammonium chloride
 - C. Mercurial diuretics
10. Meat intoxication, after shunt procedures
11. Hepatotoxic agents with existing liver disease
12. Excess fatigue
13. Unknown

THE THREE STAGES

Three stages may be recognized in the evolution of hepatic coma with reversal during recovery. The duration of each stage varies from hours to weeks with progression occurring either gradually or precipitously. First is the period of impending coma characterized by changes in consciousness, with euphoria, absentmindedness, confusion, drowsiness and inappropriate behavior. Inability to perform simple mental agility tests, such as the "hundred minus seven" test, may be the earliest recognized manifestation. Neurological examination often reveals the characteristic "liver flap" described by Adams and Foley.⁵ This is demonstrated most effectively "by having the patient hold his arms and hands outstretched with the fingers spread apart.

Depending upon the severity of the process, as this posture was maintained there appeared at irregular intervals of a fraction of a second to seven seconds, a series of movements consisting usually of lateral deviations of the fingers, flexion-extension of the fingers at the metacarpophalangeal joints, and flexion-extension of the wrist. The movements are rapid and arrhythmic. They tended to occur in bursts at the rate of one or two per second." Other neurological abnormalities of a transient nature may also appear.

The second stage is that of stupor. The patient lapses into sleep, but may be aroused for short periods of time, although confused when awake. When the patient is able to cooperate, a "liver flap" may be demonstrable as well as other neurological signs. A characteristic electroencephalographic pattern has been described.⁶

The third stage is coma itself. The patient is flaccid and may not respond to even noxious stimuli, depending upon the depth of the coma. Breathing may be deep and regular. Fotor hepaticus may be prominent and is a grave prognostic sign. Fever is often present.⁷

DIAGNOSIS

When the patient is seen initially, he is frequently either in stupor or coma and a differential diagnosis of the latter is necessary (Table II). The history is of utmost importance and all possible sources of information must be questioned, as the early prodromal symptoms may clearly indicate the nature of the process. Jaundice is not necessarily present, although Foulk, *et al.*⁸ reported some icterus in 47 out of 52 cases. Other indications of severe liver disease such as ascites, edema, spider angiomas may also be absent.

TABLE II
DIFFERENTIAL DIAGNOSTIC POSSIBILITIES

1. Cerebrovascular accident
2. Subdural hematoma
3. Diabetic coma
4. Insulin shock
5. Bleeding peptic ulcer with shock
6. Myocardial Infarction
7. Trauma

A history of recent paracentesis, pneumonia, upper respiratory infection, duodenal ulcer, upper gastrointestinal hemorrhage or recent transfusions will be of great aid in suggesting the immediate precipitating factor in hepatic coma.

Physical examination may reveal signs of shock,

hepatic decompensation or pneumonia. The state of consciousness and orientation must be evaluated rapidly. The presence of a "liver flap" or other neurological abnormalities will help establish the diagnosis.

Laboratory examinations that are useful and may be performed in most hospitals include a blood count, hematocrit, urinalysis, blood sugar, blood urea nitrogen, serum sodium, potassium, chlorides and CO_2 , electrocardiogram and stool examination for occult blood. Examination of the stomach contents may detect blood and the tube may subsequently serve for feedings if necessary. More esoteric tests such as arterial ammonia and blood or urine amino acid determinations are research tools and not needed for diagnosis or treatment. An electroencephalogram is unnecessary, but if available may give confirmatory evidence.

Liver function tests are of value only in that they indicate the degree of hepatic damage, but are in no way correlated with the depth of hepatic coma nor indicate the reason for going into coma.

TREATMENT SHOULD BE INDIVIDUALIZED

It is important that treatment be individualized depending upon the precipitating cause of the coma and the nature of the underlying hepatic disease. Spontaneous remissions may occur, even with deep coma, so that the evaluation of results requires critical analysis.

Certain basic elements of care apply in all cases. The patient must receive the utmost attention and will require constant vigilance on the part of the nursing staff, house staff, and attending physician. Vital signs must be checked frequently, especially if shock is present. Sources of bleeding, such as esophageal varices or duodenal ulcer, must be determined. Blood replacement and the use of Sengs-taken-Blakemore tube or other indicated techniques⁹ to halt bleeding must be instituted immediately. Bowel flushing with milk of magnesia promotes the elimination of blood. Shock may be combatted with the use of pressor agents as norepinephrine. Sedation is kept at a minimum and care taken to: (1) avoid agents such as morphine and short acting barbiturates which are detoxified in the liver; and (2) prevent further depression by using small doses of meperidine (Demerol) or phenobarbital. Initially, a diet high in carbohydrate and limited to 30 Gm. of protein should be utilized. The early infusion of glucose is felt to be helpful since it provides calories, helps replete liver glycogen

stores, inhibits ammonia production and corrects dehydration.

A serious complication of hepatic coma is the development of electrolyte abnormalities which must be recognized and treated.¹⁰ Patients in hepatic coma may have a mild metabolic acidosis, hypokalemia and hyponatremia, especially if they have been on low sodium diets for ascites. Paracenteses may further deplete the body of its sodium stores. Accordingly, frequent electrolyte determinations and replacement of losses are necessary. The electrocardiogram is a great aid in following potassium imbalances.

Potent vitamin mixtures, including 200 mg. of ascorbic acid, 100 mg. of thiamine chloride, 300 mg. of niacin, 50 mg. of riboflavin and 20 mg. of vitamin K, should be added to each liter of intravenous fluids.¹¹

Recent additions to the therapeutic regimen have been the use of glutamic acid, steroids, antibiotics and arginine. Brain tissue in the presence of glucose will preferentially synthesize glutamine from ammonia and glutamic acid.¹² In recent years glutamic acid has been used to decrease elevated arterial ammonia levels found in hepatic coma. After the first enthusiastic reports of this therapy there have been additional studies finding it to be of little value.^{13,14,15,16}

The use of steroids is purely empirical. Its value in the presence of shock is undisputed, but no really good rationale can be presented for its use in hepatic coma. Some observers feel that cortisone and corticotrophin in large doses are of great help.^{17,18,19}

Antibiotics are necessary in the presence of co-existing infection. Their use without this indication is based upon the supposition that suppressing the normal bacterial flora of the gastrointestinal tract decreases production of urease, an enzyme which reduces urea to ammonia. Phear and Ruebner, in their *in vitro* studies, could not substantiate this theory.²⁰

The use of arginine is still in the experimental stage and this amino acid is not available for general use.²¹

CASE REPORTS

CASE NO. 1

E. M., a 60 year old white male cirrhotic was readmitted to the West Haven VA Hospital on December 12, 1955 with a one day history of increasing lethargy and confusion. His first episode of liver decompensation was in 1949 and during the seven months before admission he had been hav-

ing biweekly abdominal paracenteses with removal of up to 14 liters of fluid each time. The patient was on a 200 mg. sodium diet and received multiple infusions of serum albumin for hypoalbuminemia. He gradually developed lethargy, somnolence, and confusion about 72 hours after his last abdominal paracentesis.

Physical examination: Blood pressure 122/78; pulse 96; pupils dilated but reactive; sclerae not jaundiced; liver and spleen not palpated; one-plus peripheral edema; numerous spider angiomas; "liver flap"; positive Babinski reflexes bilaterally; cogwheeling spasticity of the upper extremities.

Laboratory examinations: 12/12/55: Hematocrit—43 per cent; blood urea nitrogen—26.1 mgm. per cent; sodium—123.4 meq./liter; potassium—5.8 meq./liter; CO_2 —18 meq./liter; chlorides—97 meq./liter; bilirubin 2.6 mgm. per cent. 12/14/55: Sodium—134 meq./liter. 12/16/55: Alkaline phosphatase, thymol turbidity, fasting blood sugar—normal.

Course in the hospital: Hepatic coma was felt to have been precipitated by paracentesis and the accompanying hyponatremia. The patient was given 300 cc. of 3 per cent saline and 50 cc. of salt-poor albumin. One Gm. of oxytetracycline and 50 Gm. of sodium glutamate were given daily intravenously with glucose and vitamins. By December 17, 1955 his mental status was much improved, the "liver flap" and Babinski's having disappeared within 24 hours of commencing therapy.

That evening the patient bled massively from the gastrointestinal tract and became lethargic and confused. Blood urea nitrogen rose with a rapidly falling hematocrit and he was treated with packed red blood cell transfusions, salt-poor albumin and intravenous oxytetracycline. By December 23 he had returned to a normal state of consciousness after complete cessation of bleeding and on December 29 he was discharged ambulatory from the hospital.

Over the next fifteen months abdominal paracentesis was performed periodically and salt-poor albumin was given each time. He had one additional episode of disorientation and dehydration following vomiting precipitated by a fecal impaction. This was controlled with intravenous fluids, albumin and sodium glutamate.

COMMENT

This patient's first episode of hepatic coma was probably precipitated by abdominal paracentesis and the hyponatremia resulting from repeated taps and dietary sodium restriction. Many neurological abnormalities, including a "liver flap," were present. The patient responded to electrolyte replacement, albumin, antibiotics and sodium glutamate only to relapse into coma after severe hemorrhage. This also proved reversible, with administration of blood as well as the other adjunctive measures.

CASE NO. 2

A. P., a 43 year old white female alcoholic was admitted to G. H. on March 10, 1956 with a six-week history of ascites and anorexia. Twenty-four hours prior to admission the patient developed intermittent epistaxis, weakness,

nausea and vomiting. The diagnosis of Laennec's cirrhosis was made in 1954 by liver biopsy.

Physical examination: Emaciated but cooperative and rational; moderate jaundice; ascites; rounded liver edge at the costal margin; numerous spider angiomas; no palpable spleen; no "liver flap" or other neurological abnormalities.

Laboratory examinations: 3/11/56: urine—negative; hemoglobin—69 per cent; W.B.C.—10,150; prothrombin time—50 per cent; non-protein nitrogen—19 mgm. per cent; bilirubin—1.2 mgm. per cent; stool—two plus guaiac positive. 3/19/56: Sodium—120 meq./liters; potassium—5.6 meq./liter; chlorides—99 meq./liter; CO_2 —50 volumes per cent; alkaline phosphatase—2.4 Bodansky units; albumin 2.5 Gm. per cent. 3/26/56: Non-protein nitrogen—39 mgm. per cent; chlorides—113 meq./liter; sodium—115 meq./liter; potassium 4.95 meq./liter. 4/2/56: Hematocrit—23 per cent; CO_2 —27 volumes per cent; sodium—140 meq./liter; potassium—4.1 meq./liter; chlorides—118 meq./liter. 4/5/56: Hematocrit—16 per cent.

Course in the hospital: On March 11, 1956 abdominal paracentesis yielded 500 cc. of dark yellow fluid. Subsequently the patient became progressively weaker. On March 24, 1956 a sweet odor to the breath and tarry stools were observed. The patient became stuporous and appeared moribund despite blood transfusions. In the evening an infusion of 10 per cent glucose in water containing 100 milligrams of cortisone, B-complex vitamins and ascorbic acid was started. This was repeated in twelve hours. Within that time, the patient responded dramatically, being fully alert and sitting up in a chair eating breakfast.

Decreasing doses of oral cortisone were given and this patient did well until April 1, 1956 when bleeding recurred. Blood was replaced along with an infusion of 10 per cent glucose in water containing 150 mgm. of hydrocortisone and 50 micrograms of Vitamin B¹². A Sengstaken tube was inserted and inflated to control the bleeding. On April 2, 1956 the patient became deeply comatose and despite continued and vigorous blood, fluid and electrolyte replacement with cortisone and vitamins, she expired on April 6, 1956. Autopsy showed advanced Laennec's cirrhosis and ruptured esophageal varices.

COMMENT

This is another example of a patient who had two episodes of hepatic coma. The first was possibly related to the paracentesis and moderate bleeding and responded dramatically to therapy. The second episode of liver coma followed severe gastrointestinal bleeding and proved fatal. The low serum sodium level present in this case before coma and not actively treated is a common finding in liver disease and despite the return to normal electrolyte levels, the course of the patient's basic illness was not influenced.

CASE NO. 3

J. B., a 36 year old white male alcoholic was admitted to the West Haven VA Hospital on October 11, 1956 be-

cause of jaundice, epigastric distress and anorexia of two weeks duration.

Physical examination: Blood pressure—170/80; pulse—124; severe jaundice; numerous spider angiomas; abdominal distension; marked hepatosplenomegaly; two plus peripheral edema.

Laboratory examinations: 10/11/56: Hematocrit—39 per cent; bromsulfalein retention—6 per cent in 45 minutes; blood urea nitrogen—6 mgm. per cent; serum bilirubin—7.76 mgm. per cent; serum albumin—1.65 Gm. per cent; globulin—4.82 grams per cent. 10/31/56: serum electrolytes normal. 11/6/56: Blood urea nitrogen—56 mgm. per cent. 11/8/56: Serum bilirubin—25.75 mgm. per cent; alkaline phosphatase—11.15 Bodansky units; sodium—124.8 meq./liter; potassium—3.1 meq./liter; chlorides—87 meq./liter; hematocrit—34 per cent. 11/17/56: W.B.C.—23,300/cu. mm. 11/22/56: Potassium—2.7 meq./liter. 11/26/56: Potassium—1.65 meq./liter. 11/29/56: Potassium—3.7 meq./liter.

Course in the hospital: Initially the patient responded to the usual regimen, but in ten days began to develop ascites requiring abdominal paracentesis. Esophagoscopy revealed varices and esophagitis. Infusions were given to correct electrolyte abnormalities. On November 16, 1956 severe hematemesis occurred and the patient became lethargic and then semistuporous. Blood, corticotrophin and chlortetracycline were administered intravenously and a Sengstaken tube was inserted and inflated for three days. Within 24 hours the bleeding stopped and he became much more alert. On November 26, 1956 hematemesis recurred and the patient became disoriented and semistuporous. Therapy consisted of blood, glutamic acid, oxytetracycline, cortisone and electrolytes intravenously. Milk of magnesia was given via the reintroduced Sengstaken tube to flush the blood out of the bowel. On November 29, 1956 he died.

COMMENT

This patient had "galloping cirrhosis" complicated by severe gastrointestinal hemorrhage. After an initial bout of hematemesis, he responded to specific measures including blood and replacement of electrolytes as well as nonspecific treatment with steroids, chlortetracycline and glutamic acid, only to succumb following a second gross bleeding episode. The electrolyte derangement was corrected. This patient obviously had severe parenchymal liver damage with jaundice, hypoproteinemia and hypokalemia.

CASE NO. 4

E. C., a 32 year old white female with a history of heavy alcoholic intake was admitted to Griffin Hospital on April 20, 1956 for jaundice of two weeks and lethargy of two days duration.

Physical examination: Blood pressure—118/70; deep, irregular respirations; temperature—100.2 F.; semistuporous; moderate jaundice; numerous spider angiomas; tender liver enlarged to the level of the umbilicus; three plus peripheral edema; variable positive Babinski reflexes, ankle

clonus; hyperactive deep-tendon reflexes alternating with areflexia and spasticity.

Laboratory examinations: 4/20/56: Serum bilirubin—10 mgm. per cent; hemoglobin—65 per cent; W.B.C.—12,600 per cu mm. with a shift to the left; urine positive for bile and one plus proteinuria; sodium, CO₂, and chlorides—normal; potassium—1.9 meq./liter; serum albumin—2.2 Gm. per cent; prothrombin time—30 per cent; cephalin flocculation—two plus in 48 hours; electrocardiogram consistent with severe hypokalemia. 4/21/56: Potassium—2.6 meq./liter. 4/23/56: Sodium—155 meq./liter; potassium—2.9 meq./liter; chlorides—114 meq./liter.

Course in the hospital: The patient became deeply comatose with a temperature of 103.8 F. within three hours after admission. She was given an infusion of 10 per cent glucose in water with Vitamin B complex, thiamine, Vitamin K, 40 milliequivalents of potassium chloride, 500 mg. of chlortetracycline, and 150 mg. of hydrocortisone. This infusion was repeated with the potassium chloride reduced to 20 milliequivalents every eight hours for forty hours. In addition, the patient received gastric feedings, Demerol for restlessness and nasal oxygen. After twelve hours, she became responsive, vital signs returned to normal and varying neurological signs persisted. After twenty-four hours her sensorium cleared and in 40 hours she was alert, cooperative, spoke frequently and no longer had abnormal neurological signs. Antibiotics and steroids were continued, first intermuscularly and then by mouth for a total of seven more days. The patient was up and about on the fifth day and was discharged completely asymptomatic and ambulatory on the thirtieth day.

COMMENT

This patient presented acute decompensation of the liver with coma, varying neurological findings and some hypokalemia. Treatment was directed specifically at correction of the electrolyte and fluid abnormalities. Because of the severity of the coma, cortisone and chlortetracycline were added. Gastric feedings are important when long term parenteral therapy is anticipated.

CASE NO. 5

E. Z., a 72 year old white female was admitted to Griffin Hospital on July 12, 1956 with a one year history of recurrent, resistant congestive heart failure with anasarca. There was a long history of moderately heavy alcohol ingestion with good dietary intake. Six months prior to admission gastrointestinal and gall bladder radiological examinations were normal.

Physical examination: Blood pressure—140/60; temperature 100.8; moderately icteric sclerae; ascites; liver edge palpable four fingerbreadths below the costal margin; three plus peripheral edema; alert and cooperative.

Laboratory examinations: 7/12/56: Hematocrit—20 per cent; W.B.C. 15,150 cu./mm.; fasting blood sugar—125 mgm. per cent; non-protein nitrogen—42 mgm. per cent; alkaline phosphatase—3.95 Bodansky units; serum bilirubin—1.32 mgm. per cent; prothrombin time—less than 10 per cent;

Coomb's test negative; cholesterol 80 mgm. per cent with 59 per cent esters; serum albumin 3.32 Gm. per cent; reticulocytes—16.6 per cent; platelets—62,000/cu.mm. 7/14/56: Bone marrow showed megaloblastic arrest; gastric analysis—unsatisfactory. 7/16/56: Sodium—125 meq./liter; prothrombin time 33 per cent; cephalin flocculation—four plus in 48 hours; stools—negative to guaiac. 7/17/56: Serum bilirubin—31 mgm. per cent; reticulocytes—9.5 per cent; urine positive for bile and urobilin. 7/20/56: Sodium—118 meq./liter; bilirubin—6.7 mgm. per cent. 7/24/56: Reticulocytes—18.8 per cent. 7/30/56: Hematocrit—30 per cent; serum bilirubin—4.0 mgm. per cent; cephalin flocculation—normal.

Course in the hospital: The patient was started on a salt-free diet and mercurial injections while being investigated for the cause of her anemia and jaundice. On the evening of July 15, 1956 she developed a fever of 105° F., became stuporous and then comatose. An infusion of 10 per cent glucose in water containing 150 mg. of cortisone was given and this was repeated every eight hours. Within 12 hours the patient responded dramatically, becoming fully alert. The cause of the anemia was not certain but her response to Vitamin B¹² therapy suggested pernicious anemia. By July 18, 1956 her temperature was normal; she became ambulatory and the jaundice subsided. On July 31, 1956 a liver biopsy was done, but was not diagnostic. On August 1, 1956 the patient was discharged ambulatory.

COMMENT

This is an illustration of a patient with a confusing clinical picture who developed severe transient jaundice of unknown etiology and a severe anemia also of questionable etiology. While in the hospital, she went into hepatic coma during an acute febrile episode and responded to fluid replacement plus cortisone. There was no evidence of Laennec's cirrhosis or obstructive or hemolytic jaundice, but aggressive, empirical therapy was rewarding.

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*Are our automotive engineers doing
anything to reduce highway accidents?
How can accidents be reduced?
What part can the physician play in
solving this great problem?
This is real preventive medicine.*

THE ROLE OF PREVENTIVE MEDICINE IN HIGHWAY SAFETY

ROSS A. MCFARLAND, PH.D., *Boston, Massachusetts*

IT is now generally recognized that the number of accidents on our highways has attained the epidemic proportions of a noncontagious mass disease. During the current year approximately 42,000 people will be killed, 400,000 permanently impaired in some way, and a million temporarily disabled. It seems only logical, therefore, that public health should assume responsibility for the control of this threat as it did earlier in the field of quarantinable diseases. In general, accident distributions show variations according to season, age, sex, and other parameters, and are considered to follow principles comparable to the basic biologic laws which influence the processes of diseases.

The physician or health officer has a direct responsibility in the prevention of accidents, not only because of his broad training in the biologic sciences and the important role played by human variables in accidents, but also because he is in a favorable position to teach while treating injuries. One of the basic laws in psychology is that memory operates most effectively when reinforced by emotion. Thus the physician should take the initiative in identifying the causes of accidents leading to their occurrence and indoctrinate patients with the principles of accident prevention while they are being treated.

The next important advances in safety are most

The Author. *Associate Professor, Harvard School of Public Health, Boston, Massachusetts*

Highway accidents fall within the province of preventive medicine and the health officer has as much responsibility for their control as he has for preventable diseases. This is the thesis ably developed here.

likely to result from more effective collaboration between the engineering and biologic sciences. The team approach is not new in medicine and has been essential to many important advances. For example, in the epidemiologic study of malaria, collaboration between the entomologist, the sanitary engineer, and other specialists was necessary to secure the basic data and bring about control. The prevention of motor vehicle accidents can similarly be furthered through the aid of the physiologist, the psychologist, the anthropologist, and the safety engineer in cooperation with the physician to try to bring about better control.

SOME FINDINGS CONCERNING HOST FACTORS

The nature of the important requirements of safe driving may be revealed through a "job analysis" of driving. Not only must the driver first learn a series

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of complex coordinated tasks involving both hands, both feet, vision, hearing, and touch, to the point where they are automatic—making judgments of changing space-time relationships must also be learned. The short time intervals within which reactions must be completed mean that foresight, planning, and the appreciation of hazards are major factors in safety. It is probable that more continuous attention from moment to moment is required of the driver of a motor vehicle than of the operator in any other type of transportation, including the airplane.

Many specific attributes of the "host" have been investigated, but it is apparent that no single characteristic of drivers is outstanding in accounting for a large proportion of accidents on the highway. Those attributes most clearly having a relationship to accident frequencies include low intelligence, youthfulness, and a personality make-up in which social responsibility is weak or lacking.

Drivers of about 25 years of age and younger have accidents more frequently, in relation to their numbers, than do drivers in the age groups 30 through 60 or 65. The most recent and most complete information (from Connecticut) indicates the rates are highest for the youngest drivers, i.e., age 16, and the rate decreases with each additional year of age to about age 30 or 35, remaining stable from this point on. The factors responsible for the high rate of the younger drivers are believed related to (a) inexperience, and (b) temperamental qualities of youth.

A promising method for detecting accident repeaters is based on the concept that "a man drives as he lives." Until recently it was widely accepted

that "accident-proneness," an elusive and not very precisely defined concept, was a major cause of highway accidents. Statisticians, however, have shown that finding a small proportion of drivers responsible for a relatively large proportion of the accidents may not indicate accident-proneness, but be the result of chance. Even when accidents occur by chance, some individuals will have more than others. This is illustrated in Table I.

TABLE I
CHANCE DISTRIBUTION OF 300 ACCIDENTS IN A GROUP OF 500 PERSONS

NUMBER OF ACCIDENTS, PER PERSON	THEORETICAL NUMBER OF CASES, BY CHANCE
0	275
1	165
2	49
3	10
4	1

When statistical studies on motor vehicle accidents have been carried out taking the influence of chance into account, only a relatively few drivers appear to be unusually susceptible to accidents as a result of innate characteristics, and hence could be termed "accident-prone." Also, studies over successive periods of time have shown that it is not the same persons who have repeated accidents in the different periods. For these reasons, it seems preferable to use the term "accident-repeaters" and to study the circumstances of accidents in a given period of time.

Another approach has been clinical. The psychiatric study of accident-repeaters has led to the view that certain persons may have accidents on the

TABLE II
THE RATIO OF THE ACCIDENT RATES OF UNTRAINED TO TRAINED DRIVERS IN COMPARABLE PERIODS OF TIME

	EXPOSURE IN DRIVER MONTHS	ACCIDENTS	ACCIDENT RATE PER 1,000 DRIVERS PER MONTH	RATIO OF ACCIDENT RATES
Men and Boys				
Untrained	123,865	979	7.9	1.8
Trained	61,818	265	4.3	
Women and Girls				
Untrained	42,581	110	2.6	2.2
Trained	62,272	72	1.2	

basis of unconscious needs and motivations. It is important to recognize that while emotional states are undoubtedly of significance in many accidents, the application of the above concept for the detection of accident-repeaters is limited by the subjectivity of the method. It would be an unimaginative psychologist or psychiatrist who could not find some indications of the conflicts and repressed feelings consonant with this theory, particularly after an accident has occurred.

A more objective and useful procedure for identifying accident-repeaters has been suggested by Tillmann, in Canada, as a result of clinical findings that maladjustment in meeting the demands of life is far more frequent among accident-repeaters than in accident-free drivers. On the basis of records of contact with adult and juvenile courts, venereal disease and public health clinics, credit bureaus, and social service agencies, there was a marked difference between a group of accident-repeater drivers and two separate groups of accident-free drivers. Sixty-six per cent of the accident-repeaters were known to one or more of these agencies, compared to 6 per cent of the accident-free. These findings were corroborated in a study at the Harvard School of Public Health when similar procedures were used with a large sample of truck drivers. In addition, accident-free and accident-repeater drivers were carefully matched and a statistical analysis made to determine the relative importance of the various items. In this way, weighted scores were assigned to the items, and when these were applied in a new sample, the accident-repeater and accident-free drivers were identified with an accuracy of about 80 per cent.

Adequately training drivers appears an effective way of reducing accidents. Several controlled studies on the effect of high school driver training programs indicate that the students with formal training have lower accident and violation rates than those who learned to drive in other ways. Table II summarizes the findings from eleven such studies.

The role of fatigue in highway accidents may best be understood from the standpoint of the characteristic ways in which skilled performances like driving deteriorate during protracted periods of exercise. An early effect is a disturbance of the timing of responses. Later on, the driver tends to react to particular stimuli, ignoring others. Errors, when recognized, tend to be overcorrected. An important effect is a loss of insight into the quality of per-

formance, and a failure to recognize the full potentialities of dangerous situations. In addition to the hours of driving, consideration must also be given to such factors as amount and quality of previous rest, the nature of activities prior to driving, and concurrent emotional stress.

Driving skill is adversely influenced in many persons with as little alcohol in the blood as 0.03 and 0.04 per cent. Controlled studies show that the likelihood of accidents increases consistently as the alcohol in the blood increases from the lowest levels. This is illustrated in Table III. In a more recent study the risk at 0.10 per cent blood alcohol was estimated more than twice that at 0.05 per cent while the risk at 0.15 per cent appeared at least tenfold (cf, 19). It is of interest to note that blood alcohol levels exceeding 0.10 per cent were found in 52 per cent of the series of 269 cases in autopsies of drivers killed in accidents in Nassau County, N. Y. This same trend has been observed in two other studies.

TABLE III
RELATIVE FREQUENCY OF AUTOMOBILE ACCIDENT CASES FOR
DIFFERENT ALCOHOL CONCENTRATIONS

PER CENT ALCOHOL IN BLOOD	NUMBER OF ACCIDENT CASES PER 100 CONTROL CASES
None	9
Less than 0.04	45
0.04-0.07	21
0.08-0.11	53
0.12-0.15	146
0.15 and over	577

HUMAN-AGENT RELATIONSHIPS

A basic principle in the new discipline known as human engineering is that vehicular design must be intimately related to the biologic and psychologic characteristics of the operators. Studies in this field have shown that many accidents on the highways and in industry have occurred because sufficient attention was not given to human capabilities and limitations in the original design. Frequently errors, usually attributed to human failure, may actually be induced by poor design features. Several illustrations may help to clarify this point of view.

The first is taken from the field of aviation. Confusion arose when the controls for operating the flaps and landing gear were located too close together, or reversed from one plane to another. In one 22-month period during World War II, inattentive manipulation or mistaken identity of these

controls caused 547 accidents in one of the services. Of these, 273 were in advanced trainers and 184 in fighters, bombers, and transports. Another example relates to a serious highway accident which resulted when the driver of a modern automobile, traveling at high speed at night, inadvertently shut off the headlights in the belief that he was pushing the cigar lighter. The knobs for these two were identical in shape and size and were located next to each other on the dashboard.

The crash and impact forces in a large proportion of motor vehicle accidents which have been fatal are within the physiologic limits of survival of the human body, if the momentum of the body can be properly checked and the forces dissipated by certain design features. Steering wheels, doors which pop open on impact, instrument panels, windshields, and the back of the front seat have been identified as major structural features causing injury to vehicle occupants during crashes. Ejection through opened doors was found to be the greatest single factor in injury, with ejection more than doubling the risk of moderate though fatal injury. On the basis of such information improvements were introduced in a number of 1956 cars. Preliminary findings from the Automotive Crash Injury Research Project at Cornell indicate a substantial reduction in ejection rates in the new models, due mainly to improved door locks. A reduction of crushing injuries to the chest in drivers is also apparent with the improved steering wheel design, and a comparison of similar accidents involving cars with and without seat belts suggests about a 60 per cent improvement in injury with the use of the belts.

HOST-ENVIRONMENTAL RELATIONSHIPS

Several of the physical variables in the environment have important effects on the safety and efficiency of driving. Such factors as the level of illumination, the concentration of carbon monoxide in the air, the condition of the roadway, and the presence of traffic need to be understood in terms of the interaction of the host, agent, and environment in creating hazardous situations. In some instances, these relationships can be expressed quantitatively. A few examples can be given to illustrate the principles involved.

Older drivers might be expected to encounter greater difficulty in driving at night than younger ones. If the illumination is low, they require more light than do younger persons to detect objects

which are near the lower limits of visibility. The final adaptation levels for subjects ranging from 20 to 70 years of age are plotted against age. From these data it is calculated that for a dim light or object to be just seen by an eye in the dark, the illumination must be doubled for every increase of 13 years in age. In this connection the use of tinted windshields at night by older drivers may present special hazards since the tinted glass further reduces the effective illumination.

Various studies have shown that the volume of traffic tends to decrease during inclement weather, but accident rates per unit of travel are greater. Apart from considerations relating to visibility, an important "host" factor is that of the driver's training and experience in the operation of vehicles under adverse circumstances. For example, when skidding accidents on the Pennsylvania Turnpike were analyzed, it was apparent that the particular practices carried out by drivers often precipitated or prolonged the skidding. It was concluded that a lack of training in proper methods of operating on slippery roads was an important causal factor in these incidents.

The lethal effects of exposure to carbon monoxide are well known. With exposure to subclinical concentrations of this gas, there are also deleterious effects upon various human reaction systems, which may constitute hidden factors in numerous accidents. For example, one early effect is a reduction in the sensitivity of night vision. Other insidious effects include reduced alertness and drowsiness. While the usual source of carbon monoxide in automobiles is the exhaust from the engine, a driver may absorb additional amounts of the gas from tobacco smoke inhaled from cigarettes.

Driving practices at any one time tend to be adapted not to the conditions being newly encountered, but to the traffic situation met just previously.

Quality control statistics can be used to detect unusual trends in accidents, and to indicate the need for a prompt analysis of the situation to determine the causes of changes in accident rates.

SUMMARY

In this view accidents are considered to result from the interactions of three different factors: (1) the host (the worker, or driver), (2) the agent (or equipment), and (3) the environment. The host is of primary medical concern, and the physician, because of his knowledge of the characteristics of

the host, is in an especially advantageous position to contribute to the analysis of accident causes, and to educate in safety while treating.

One of the most important working rules is that the job to which a person is assigned should be related to his behavioral, psychologic, and physical characteristics. The influence on safety of various temporary states in the individual, such as fatigue, emotional problems, and the effects of alcohol, can hardly be overemphasized.

Methods of detecting the accident-repeater in advance have not yet been perfected, but the most promising approach is based on the concept that "a man works (or drives) as he lives." At the very least, medical officers and industrial physicians can identify those with a record of repeated accidents, and through clinical approaches determine how well adapted they are to their jobs and responsibilities.

One important way of improving safety is by the design of equipment in terms of human capabilities and limitations. This involves the closer integration of the host-agent relationships through the application of the principles of human engineering. Such an approach utilizes an advance analysis of

possible faults in the design of the equipment and can aid substantially in the reduction of accidents.

The third phase of the epidemiologic approach, the host-environment relationship, is concerned with the effect of the physical variables on the individual. Such factors as the level of illumination, the temperature and humidity, carbon monoxide and other toxic agents are of importance. For each of these variables there are reasonably well defined zones of comfort and discomfort, and ranges where the efficiency of human performance is reduced to the detriment of safety.

In conclusion, the physician of today and the future can play an important role in the prevention of accidents. The next significant advances will be obtained by carefully controlled experimental and clinical studies, epidemiologic surveys, and statistical analysis, and with the medical officer working in close collaboration with other biological specialists, engineers, and administrative officers. Finally, in the words of the poet, T. S. Eliot—

"These are only hints and guesses
Hints followed by guesses; and the rest
Is prayer, observance, discipline, thought,
and action."

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EDITORIALS

The Accident Picture

Do you have safety belt equipment in your automobile? Should the manufacturers install governors on automobile motors? Are you aware of the fact that Connecticut has poison control centers?

Health Information Foundation released in October valuable information on accidents in the United States. Accidents are the fourth leading cause of deaths in this country, and the leading killer of children and young adults. While on-the-job accidents have dropped from 19,000 in 1928 to an estimated 14,300 in 1956 and while there has been a substantial reduction in mortality from public accidents, excluding those due to motor vehicles in public places, the picture as it portrays accidents in the home and on the highway is less encouraging.

The American home was involved in nearly 30 per cent of all accidental deaths in 1956 and the number of those has averaged around 30,000 each year since 1928. Even blacker is the motor vehicle accident picture. In 1956 over 40,000 persons died as a result of such accidents, the largest number ever recorded. The rising number of deaths alone, however, tells only part of the story. Since 1900 the U. S. population has more than doubled, and so the death rate per 100,000 persons is a better measure of risk. This rate, like the number of deaths, reached peaks in 1931, 1937, and 1941. After declines during World War II the rate climbed slowly, reaching 25.7 in 1956, still under the former high levels.

As a result of the great increase in motor vehicle

production in this country (from 4,000 in 1900 to over 9,000,000 in 1955) and the phenomenal rate of increase in mileage traveled (an average of just under 10,000 miles per vehicle in 1956), a more realistic measure of the motor vehicle risk is the death rate per 100 million vehicle miles. This declined consistently from a peak of 16.7 in 1934 to a record low of 6.3 in 1954, followed by a slight rise to 6.4 in 1955 and 1956. This index suggests that safety in motor vehicle travel has actually increased substantially since early in the century.

The greatest achievement has been the reduction in pedestrian deaths during the past 20 years from 15,500 in 1937 to just under 8,000 in 1956. Three fifths of the total pedestrian deaths in 1956 were in the 45-and-over age group.

The cost of accidents is appalling. Including medical services, wages lost, and property damaged it reached last year 11.2 billion dollars, almost as much as Americans spend for all private medical services.

George Bugbee, president of Health Information Foundation states that "our accident record, particularly over the national holiday weekends, proves that doctors, hospitals, and safety engineers can do just so much. It is still the individual who carries the main responsibility for his own safety and health."

Man Hours Wasted

We have asked a busy general practitioner to comment on an article "The Family Physician in

Group Practice" that appeared in a recent issue of the *American Journal of Public Health*. It was a factual analysis of the subject the title denoted but the authors expressed no opinion on whether the time spent by general practitioners in group practice was economically utilized. Our general practitioner commented pointedly on this and we will quote:

"The article stated that each general practitioner averaged a work week of 48 and one half hours. My week averages 60 to 70 hours working time, not "on-duty" time. What a waste of medical manpower to work only a 48 hour week! Has the medical profession become imbued with the labor union philosophy of working fewer hours and limiting production by decree? *Time* magazine, November 4, 1957 issue, states that by 1975 medical schools will have to graduate 15,000 doctors annually instead of the present 8,000 in order to meet the demand. The article details the medical schools' troubles. Would it not solve many problems and avoid such troubles by having the doctors increase their working hours by 25 per cent? I know of no valid reason why doctors should not work a 60 hour week.

"The second thought on reading the article concerned the number of house calls the general practitioner makes per month . . . 28 to 30 a month it said. I rapidly went over one of my recent months and found that I made 120 to 130 house calls. Practically all were too sick to come to the office. If the general practitioners in the article made so few house calls; either the type of practice is very different from mine or they hospitalized many patients who could have been cared for at home. This raises the cost of medical care, creates a shortage of hospital beds, and is another step towards socialized medicine. It is well recognized that it is easier to see five hospital patients than it is to make five house calls. But should hospitalization be for the convenience of the physician? Or should it be because the patient cannot be cared for adequately at home?"

This puts a new slant on some of the problems of medical service.

National Medical Meetings on the Up and Up

Just before attending a large national surgical meeting recently we were talking about it with a

business man from one of the Middle Atlantic States. He said, "A friend of mine was in Atlantic City not long ago while a medical meeting was in progress. He said he never saw so many wild parties and so much drinking. I guess doctors have to relax sometime and it is best when they are away from home and not under close observation." Admitting that there might be some truth in the latter observation, we couldn't quite agree with the former. Our experience at the convention confirmed what our previous experience has always been, that it was an extremely sober affair.

Never have we seen such a large body of men and such a large gathering in a resort location with their minds so much on the serious business at hand. The meeting rooms were crowded from the first hour of the first day. In fact, a crowd of several hundreds was waiting to be registered and admitted half an hour before opening time, which was at 8:30 A. M. So many questions were submitted to the doctors participating in the panel discussions that they were literally swamped. Informal discussions in the corridors, on the boardwalk and in the hotels appeared to be generally intense, well informed and enthusiastic.

No subject seemed to be too special or no technique too advanced to fail to draw a large audience. The greatest interest seemed to be attached to the latest developments in cardiovascular surgery, which are undoubtedly beyond the scope of practice of the majority of surgeons who attended the sessions and viewed the exhibits which described or illustrated them. Still it was amazing to hear from those attending the meeting the limits to which surgery has been extended around the country even at a distance from the large medical centers.

A great number of the surgeons came with their wives, if not their whole families. What extra curricular entertaining and celebration was evident had chiefly the air of family entertaining at home. Even the reunion cocktail parties were noticeably serious and sober. Probably the most daring thing any one did was to enter the auction rooms on the boardwalk.

There is little question today that scientific meetings, which are merely statewide in scope, are suffering in attendance, even where they offer outstanding speakers. The combined appeal of superlative medical talent together with outstanding scientific exhibits and the opportunity to get away from home for a few days presented by the national

medical meetings, and finally the relative ease of travel and the opportunity for a family holiday seem to indicate that this type of meeting will continue to increase in importance, while state or countywide scientific sessions decline.

Infections In the Aged

Dr. Perrin H. Long, who acted as moderator in a panel meeting on the problems of infectious diseases in the aged* states that these conditions have become one of the most important problems in the Kings County Hospital in Brooklyn as most of the patients entering the wards are over 60 years of age. Dr. Yale Kneeland, Jr., who opened the discussion, stated that infectious diseases in the young are now a relatively small problem. He pointed out that in the aged, common respiratory infections are usually the largest problem, as in old patients upper respiratory diseases tend to shift subtly into bacterial bronchopneumonia which is usually not due to the usual types of bacteria but is apt to be caused by Type III pneumococcus or the "Friedlander bacillus." It is important to be on the alert for these insidious pulmonary infections for they can usually be controlled by chemotherapy whereas 20 years ago they often resulted fatally. In the aged pneumonic too, cardiovascular complications (congestive failure, myocardial infarct, and peripheral thrombophlebitis with pulmonary embolism) are apt to occur. Furthermore, the tendency to functional bowel disturbances with abdominal distress, and also the presence of unrecognized diabetes is much commoner than in the young. Moreover, the tendency of all infections in the aged—meningitis or salmonella invasions, for example, is to develop insidiously. Then too, tuberculosis may develop or light up, sometimes in the pericardium, in old people with fever of unknown origin, and infectious mononucleosis, generally an infection of youth, may occur. Nor must we forget that malignancy is much more common than in youth. In the treatment of the aged it must be remembered that they lack the resiliency of youth so that their nutrition must be more carefully supervised, including the ingestion of fluids, and a close supervision must be exercised over the output of fluids and solids and also over the medication. Small doses of tetracycline, 0.25 Gm. morning

and evening, are usually well borne as prophylactics against infections, and urinary infections usually respond well to Furadantin. One may sum up the situation by noting that the aged are much more likely than the young to develop disease insidiously, that it is more necessary in treating them to keep close track of their various symptoms and signs both physical and mental, that prophylaxis against infections is quite possible, and that they react satisfactorily to treatment by many of the modern drugs.

G. B.

Resurgent Remedies

The striking therapeutic phenomenon of the past half century has been the development of the so-called miracle drugs. However, the fact must not be overlooked that during the same period two other phenomena of therapeutic significance have occurred: (1) some old folkremedies have been analyzed chemically and have produced active principles of great value and (2) entirely new properties of some long-known drugs have been discovered. An example of the recovery of a valuable active principle is the isolation of ephedrine from the old Chinese folkremedy, ma huang. An example of unsuspected qualities in an old drug is the recent report of Calvert that licorice extract and juice contains a substance which mimics desoxycortone and is valuable in controlling Addison's disease.*

In the past licorice, obtained from the rhizome and roots of *Glycyrrhiza Glabra*, has been used because of its pleasant taste either as a flavoring for candy or chewing gum, as a watery solution by children who enjoyed its taste, in association with flaxseed as a demulcent cough medicine, or to mask the flavor of senna and sulphur used as a mild laxative. One wonders whether in children who frequently used licorice its adrenal stimulation may not have been beneficial in some cases. Calvert's discovery points up the necessity for reexamination of old and now almost discarded folkremedies, the use of many of which, particularly herbs as Garrison points out in his *History of Medicine*, dates back to the days of ancient Greece.

G. B.

*Bull. New York Acad. of Med., 1957, Vol. 33, No. 8, p. 552

*Medical abstracts, Jour. Amer. Med. Assn. 1954, 155, 1376.

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COUNCIL MEETING

The monthly meeting of the Council was held at the offices of the Society on Thursday, October 31, 1957. The meeting was called to order by the Chairman, Dr. Gallivan, at 4:00 P. M. There were present: Drs. Walker, Russell, Johnson, Barker, Weld, Danaher, Gibson, Feeney, Fincke, Clarke, Buckley, Otis, Archambault, Ottenheimer, Gens, Seigle, Meyers, Gardner, Dwyer, Gilman. Absent were Drs. Ogden, Ursone, Schiavetti, Starr and Thayer.

CORRESPONDENCE FROM DR. CLIFFORD

A letter from Dr. Martha L. Clifford of the State Department of Health was presented in which Dr. Clifford thanked the Council for appointing her the Society's representative to attend the Sixth National Conference on Physicians and Schools at Highland Park, Illinois, October 30 - November 2.

AMERICAN MEDICAL ASSOCIATION CONFERENCE ON CIVIL DEFENSE

It was voted that Reginald C. Edson, chairman of the Society's Casualty Planning Committee be designated the representative of the Society at the American Medical Association on Civil Defense in Chicago on November 9 and 10 and that the Society pay Dr. Edson's necessary expenses.

ADDITIONAL ALLOTMENT TO JOURNAL BUDGET

Dr. Weld explained the increasing costs of producing the Society's JOURNAL and asked that an additional allotment of \$9,000 be made to the JOURNAL for operation through the remainder of 1957. This request was approved.

BUDGET FOR 1958

Dr. Carl Johnson, treasurer, presented the budget for 1958, which had been prepared and approved by the Budget Committee, Dr. Johnson, Dr. Walker, Dr. Buckley, Dr. Weld, Dr. Barker, and which had been distributed to those present prior to the meeting. The budget as presented is part of these minutes and calls for a total budget of \$146,758.32 and recommends dues of \$33 per member for 1958. Dr. Johnson explained many points in the budget which

were discussed. The proposal was made, without motion, that dues be increased to \$35 instead of \$33. Finally the budget as presented, including \$33 dues for 1958 was unanimously approved.

COMMENDATION FOR MRS. LINDQUIST

It was voted to commend and thank Mrs. Josephine Lindquist, administrative assistant in the Society's office, for her care and thoughtfulness in preparing the 1958 budget.

COMMITTEE ON INSURANCE

The secretary asked that the Council appoint a Committee on Insurance from the membership of the Society and explained why such a step appeared desirable. The subject was favorably discussed at some length and it was voted that the chairman of the Council appoint a Committee on Insurance from the membership of the Society and that matters and proposals relating to all types of insurance for members of the Society be referred to this committee for review and report.

MATTERS REFERRED FROM COMMITTEE ON HOSPITALS

(a) Action on the Revised Medical Service and Policies for the Hospital Care of Maternity Patients by the Committee on Hospitals to be delayed until a conference can be held between the Committee on Hospitals and the Sub-Committee on Minimum Standards for Hospital Care of Maternity Patients of the Committee to Study Maternal Mortality and Morbidity. It is anticipated that this conference will be held on January 15, 1958 which is the date of the next regular meeting of the Committee on Hospitals.

(b) The Committee on Hospitals at a meeting on October 23 voted to recommend to the Council that it ask the State Commissioner of Health to create an advisory committee to the organization and operation of the Poison Information Center to be developed in the State Department of Health as authorized by action of the 1957 General Assembly and that the Joint Conference Committee consisting of the Committee on Hospitals of this Society and the Council on Professional Practice of the Connecticut Hospital Association be designated as this advisory committee. It was voted to approve this request and the executive secretary was directed to proceed to carry it out.

THOMAS PATRICK MURDOCK SCHOLARSHIP AND LOAN FUND

Dr. I. S. Otis, chairman of the Council's Sub-committee on the Murdock Scholarship and Loan Fund reported the progress that had been made by the committee and presented the draft of an agreement proposed to be made between the Connecticut State Medical Society and the Meriden Trust and Safe Deposit Company that had been prepared for the Society by Mr. Grant Nickerson, attorney, of the firm of Wiggin & Dana.

(a) It was voted to approve the agreement as presented and instruct the president of the Society to sign it on behalf of the Society.

(b) In compliance with Section 4(a) of the Agreement, the Council acting for the Grantor in the Agreement, appointed the following to be members of the Thomas Patrick Murdock Scholarship and Loan Committee: For a term of five years, I. S. Otis; four years, C. Louis Fincke; three years, Cole B. Gibson. The secretary was instructed to proceed promptly with an invitation to the president of Yale University to make an appointment to the committee as provided in Section 4(b) and the president of the University of Connecticut to make an appointment to the committee as provided in Section 4(c).

There was further discussion of the project as a whole and it was agreed that the present Sub-committee of the Council should continue to administer and direct the solicitation for funds.

COMMITTEE ON NUTRITION

The chairman announced that there had been difficulty in obtaining names of members to serve on the newly authorized Sub-committee on Nutrition of the Committee on Public Health and after further discussion of the subject with Dr. Keeney,

chairman of the Committee of Public Health, the chairman proposed that a Sub-committee of two members be named, Dr. Max Caplan, Meriden and Dr. Robert R. Levin, Hartford, and that Sub-committee be authorized to seek consultation from others as may be indicated. This proposal was approved by the Council.

ASIAN INFLUENZA

The secretary reported conversations with Dr. Victor G. H. Wallace, director of the Connecticut Regional Blood Bank to the effect that because of the epidemic of Asian influenza donations of blood to the bank have decreased markedly and will probably continue in lowered volume. In view of this short supply steps should be taken to decrease the amount of blood used for transfusions and limit it to cases of exact necessity. The subject was discussed by many and it was pointed out that the Regional Blood Bank had already warned hospitals of this emergency and that the necessity for the lessened use of blood should be realized by all physicians. No further action on the matter was deemed necessary by the Council.

RESOLUTION FROM THE JOINT COMMITTEE OF THE CONNECTICUT STATE MEDICAL SOCIETY, CONNECTICUT PHARMACEUTICAL ASSOCIATION AND CON- NECTICUT STATE DENTAL ASSOCIATION

The secretary presented the following resolution from the Joint Committee:

"The Connecticut Medical Society and the Connecticut Pharmaceutical Association request that their national organization inquire into the distribution method employed for the Asian Influenza Vaccine in order to resolve future methods of distribution of similar drug items so that they go through the satisfactory established pharmaceutical channels that exist to supply physicians."

After discussion it was voted that the delegates from this Society to the House of Delegates of the American Medical Association present a resolution to the House embodying the points in the above resolution. It was agreed that the executive secretary should prepare the preliminary draft of the resolution.

STUDENT MEMBERS

Fifty student members were elected.

ENGROSSED CHARTER

The secretary announced that after a year and one half of work the hand engrossed charter of the Society had been delivered today and was hanging

in the upstairs hall. This document is of great historic interest because it is the original Charter of the Society passed by the General Assembly in May 1794 and is believed to be the first private charter granted by the Assembly. It was hand engrossed by Jean Day Zallinger for the Society.

The meeting adjourned at 6:00 P. M.

Meetings Held in November

- 6—Council of New England State Medical Societies
- 8—Program Committee, 1958 Annual Meeting
- 11—Committee on Eye Care
- 12—Connecticut Medical Examining Board
Medical Advisory Committee, Connecticut Cancer Society
- 13—Connecticut Medical Examining Board
Blood Bank Committee
- 14—Connecticut Medical Examining Board
- 20—Committee on Maternal Mortality and Morbidity
Medical Advisory Committee to the State Commissioners of Finance and Welfare
- 26—Connecticut Medical Examining Board
Conference Committee on the State Dental Association
- 27—Sub-committee on Toxemia
Committee on Accident Prevention

Indiana State Increase Dues for AMEF

At its recent meeting in French Lick, the Indiana State Medical Society voted to raise its dues \$10 as a contribution to the American Medical Education Foundation.

Indiana is the eighth state to take such action. Others are: Illinois, Utah, California, Nevada, Idaho, Arizona, and New Jersey.

New Members

FAIRFIELD COUNTY

Herman Austrian, Trumbull
Allan E. Bayless, Bridgeport
Paul Beres, Westport
Earle L. Biassey, Stratford
Joseph G. Bisceglia, Greenwich
John E. Caton, New Canaan
Frank D'Elia, Greenwich
Charles E. Dutchess, Newtown
David D. Giardina, Norwalk
Michael Greenfield, Danbury
Donald L. Howie, Newtown

Gordon Q. Jonas, Fairfield
Edward F. Knauff, Bridgeport
Francis A. Malyszka, Bridgeport
Marilyn Ostriker, Stamford
Mildred Parker, Bridgeport
Harold E. Rhame, Jr., Bridgeport
Howard Sloman, East Norwalk
Robert E. Stanton, Greenwich
Peter J. Wick, Stamford
Ephraim Woll, Danbury

HARTFORD COUNTY

Lionel A. Ayppte, Bristol
Abraham Bernstein, New Britain
Lothar R. Candels, Avon
David M. Caldwell, Jr., Manchester
Ronald J. Czaja, Hartford
Arthur T. Davidson, Hartford
Patrick B. Friel, Hartford
Lois F. Fryer, Hartford
Howard C. Gold, Newington
Julian S. Kaiser, Hartford
Robert E. Karns, Manchester
Raymond B. Keefe, Wilson
William F. Klinkerfuss, Hartford
Rudolph V. LaMotta, West Hartford
Julian Mandell, New Britain
Edward F. D. Murphy, Windsor
Jarbour Nakhoul, Hartford
Harvey Pastel, Manchester
Charles R. Preble, Glastonbury
James C. Rouman, Hartford
Norman W. Saunders, East Hartford
Howard A. Schwartz, West Hartford
Morris J. Seide, West Hartford
R. David Sudarsky, Hartford
Edward B. Swain, West Hartford
Elliott B. Sweet, Hartford
Walter F. Tauber, Hartford
Herman Wolfson, Newington
Robert J. Williamson, Bristol
John C. Wright, II, Manchester
John P. Bachman, Hartford
Henry C. Baltrucki, Hartford
Joseph W. Belkin, New Britain
Anneliese K. Born, Hartford
George H. Bray, New Britain
Raymond A. Caldarelli, Hartford
Thomas J. Donovan, Hartford
John Giligian, Hartford
Melvin Horwitz, Manchester
Samuel A. Johnson, New Britain
Betty B. C. Yang Low, Hartford

David Luchs, Hartford
 George A. F. Lundberg, Jr., Manchester
 Robert L. Rackliffe, New Britain
 Philip Radding, Hartford
 William E. Sherpick, Farmington
 Joseph S. Stabnick, Hartford
 William H. Tripp, Hartford
 David L. Warren, Manchester
 Edward P. Wilmer, Wethersfield

LITCHFIELD COUNTY

John Haxo, New Milford
 Harold F. Schilback, New Milford

MIDDLESEX COUNTY

David C. Harvey, Stratford
 Paul Hunter, Higganum
 Gordon J. LaVella, Middletown
 Herbert M. Magram, Middletown
 Joseph A. Manzi, Middletown
 Richard T. Sweet, Middletown

NEW HAVEN COUNTY

Harold C. Anderson, Wallingford
 Arnold M. Baskin, New Haven
 Louis W. Cappucci, New Haven
 Wayne S. DeWald, Waterbury
 Ronald Fishman, West Haven
 Edmund C. Gaulden, Branford
 Jack Holden, Ansonia
 Robcliff V. Jones, Jr., New Haven
 Sung J. Liao, Waterbury
 Louis R. Mattie, New Haven
 Orlando J. Miller, New Haven
 Robert T. Miller, New Haven
 James C. Niederman, New Haven
 Joseph A. Paladino, New Haven
 James A. Riley, New Haven
 Susan B. Spencer, Madison
 Theodore N. Tausig, Middletown
 William A. Tisdale, New Haven
 Myra D. Tyler, Wallingford

NEW LONDON COUNTY

Robert W. Bain, Norwich
 Warren W. Burns, Norwich

TOLLAND COUNTY

David S. Hastings, Stafford Springs
 Brendan G. Magauran, Hazardville

WINDHAM COUNTY

Lavius A. Robinson, Jr. Danielson
 William Grillo, Willimantic

Council Resolution Stressed by Chairman of Industrial Health Committee

The resolution on Asian influenza adopted by the Society's Council and recently mailed to member physicians of the Society has been called to the special attention of physicians engaged in industrial immunization programs by Dr. John F. Kilgus, chairman of the Committee on Industrial Health.

Of particular note, Dr. Kilgus said, is that portion of the resolution concerning medical supervision which states "Medical supervision and careful techniques of administration and screening of recipients are essential."

High School Sports Injury Conferences

A guide for local medical societies interested in planning high school sports injury conferences is being published by the American Medical Association and will soon be available for distribution through state medical associations.

The booklet will include the best points of all high school conferences of this type so far presented throughout the country. Its purpose is to help in making contact sports as safe as possible from the medical standpoint and content will note certain pitfalls to be avoided and information on all aspects of the program, from medical examinations to conference press relations.

The publication has been prepared by the AMA Public Relations Department in cooperation with the Bureau of Health Education.

Dr. Otis L. Anderson Gets New PHS Post

Dr. Otis L. Anderson, for five years chief of the PHS bureau of state services on October first took over a newly created post of assistant surgeon general of Public Health Service for personnel and training. Operating in the immediate office of Surgeon General Burney, he will be responsible for all matters relating to personnel and training, including liaison with outside organizations and associations and with colleges and universities on activities in this field.

Dr. Anderson's post in the bureau of state services goes to Dr. David E. Price, now deputy chief of the bureau of medical services. Like Dr. Anderson, he has spent all of his professional life in PHS.

Special Article

Half of all Connecticut physicians die bankrupt. Do you want to know how to avoid this? Mr. Dacey tells you in the following pages.

FINANCIAL PLANNING FOR THE PHYSICIAN

The first of two articles on estate planning for the physician

NORMAN F. DACEY, *Bridgeport*

The Author. *Heads Norman F. Dacey and Associates, Financial Consultants and Trustees*

THE morning rounds finished, a group of physicians relax for a few minutes in a corner of the coffee shop. The talk drifts to money and what to do with it. One of them whom we'll call Dr. Smith, starts the ball rolling.

"I had a fellow in to see me last week who's made a fortune. He told me to buy XYZ oil—as soon as the word leaks out about a new well they've brought in, it'll go through the ceiling. I called Buyem and Sellem, the brokers, right away and bought 500 shares. When I told Harry Hottip there, who handles my account, he promised not to spread it around except to one or two of his best customers."

"That's funny," put in Dr. Jones, "Harry called me yesterday afternoon and he didn't mention it. Just told me it was time to get out of that Commode common I bought two months ago and get into Oshkosh, Ltd. I was busy as the devil and told him to go ahead and do whatever he thought best."

"Golly," chimes in Dr. Brown. "I don't know how you fellows can throw your money around like that. Look at the risks you're taking. I can't afford to chance losing my money on stocks like that. I've got a big retirement income insurance policy which takes every nickel I can scrape up."

And so it goes. One man wonders how the others manage to save so much—he keeps promising himself he'll start putting something aside next month—but, next month never comes. Another is putting everything into "the safest investment in the world"—U. S. Savings Bonds. Another buys stocks

in accordance with the month-to-month instructions of an "investment advisory service" to which he subscribes for \$60 per year.

One physician at the table doesn't listen to anyone else when it comes to investing money. He studies Barron's and the Wall Street Journal, watches the trends and invests his own money—and he hasn't done too badly at it. He's got a lot of stocks which show him a profit. Still another has a brother-in-law in Wall Street to whom he entrusts everything. This group constitutes a pretty representative cross-section of the medical profession.

A survey made a year or two back of the estates of all the Connecticut physicians who had died during the past ten years disclosed the astonishing fact that more than half of them had died bankrupt. Why should this representative group, presumably above-average in intelligence, education and income, come to such a dreary financial end?

REASONS WHY DOCTORS DIE BANKRUPT

Doctors are notoriously bad investors. This is understandable—the same demanding profession which gives them the above-average income denies them the time to think much about how to employ it safely and productively. The physicians whom we have observed above are, collectively, making the mistakes which led to the statistical results revealed by the survey. Dr. Smith invested his hard-earned money on the basis of a tip given him by a patient who, although he may have "made a fortune," probably did so by being a successful merchant or manufacturer and not by his investment ability. It was a case of the blind leading the blind.

Dr. Jones let a stock broker's phone call interrupt

his diagnosis of a patient's ailment. He was called upon to switch from one investment to another, to make a decision affecting his security, without as much thought as he would give to the purchase of a hat. Finally, he left the decision to a customer's man in a brokerage firm, not realizing that the broker is like the pharmacist who knows how to fill prescriptions but not how to write them. The broker knows how to buy and sell stocks, but not which one to buy. Like the pharmacist who is willing to suggest something for a sore throat, the broker is willing to suggest a stock for you to buy—but that's no substitute for a prescription written by a "doctor."

Dr. Brown played it safe with insurance and an annuity, and one of his colleagues hoarded savings bonds, both oblivious to the long-term melting away of the purchasing power of the dollar. Another member of our coffee club just couldn't manage to save anything. He had no system for taking it away from himself and so failed to keep the promise he made to himself that he'd begin building some security. One physician actually followed the "advice" given in a \$60 per year tipster sheet, the financial world's equivalent of the "little green sheet" sold outside racetracks. Another takes time to seriously study the market. Medicine is a demanding profession—a practitioner cannot possibly keep abreast of all that is written in his own field. How can he also master that which other men find to be equally a full-time profession—investment management? As for that brother-in-law in Wall Street—remember that Wall Street is the national headquarters of brokers, men who know how to buy and sell stocks but not necessarily which one to buy. If he *does* know his business, he's busy. Are you fair, saddling him with the unpaid job of shouldering the enormous responsibility for investing your money? Was it difficult for him to say, "No"?

These, then, are some of the reasons for the unhappy statistics regarding doctors. The figures are equally applicable to laymen, however. Of all the people aged 65 or older in this country, 75 per cent have no income at all or less than \$1,000 a year.

SOCIAL SECURITY

Consider this economic paradox: The American people have made more money than anyone else in the world. They have saved much of what they earned, as is evidenced by the millions of dollars in savings banks, building and loan associations, life

insurance cash values and government savings bonds. Why, if we have made all that money, and have saved it, do we need a Social Security Act to take care of us at age 65?

The simple answer is that the average man has traditionally received such a miserably *small return* on what he saved that he could not in his working lifetime accumulate enough to enable him to sit back at age 65 and enjoy a comfortable financial independence. It became necessary to provide security through a dole.

Strangely enough, this beneficent institution, created for the worthy purpose of bringing a measure of security to Americans, may one day be the nation's financial undoing, giving with one hand and taking away ten-fold with the other. This observation has no political overtones; our only concern is with its economic implications. If we are to plan our estates intelligently, we must work with the economic factors which are destined to affect our financial future. The Social Security Act and its consequences is one of the three or four major economic factors which we must take into account if we are to do our planning job well. An insurance company with outstanding policy obligations calling for policy reserves of three hundred billion dollars which could show only I.O.U.'s totalling thirty billion, would most certainly end up bankrupt. That is approximately the position of the Social Security Administration today. Assuming that a country like ours cannot actually go bankrupt, it is nevertheless true that spending money that we don't have on such a giant scale can only be violently inflationary and will eventually debase our currency beyond the most pessimistic present calculations. It is all important to remember this in planning our financial future.

EFFECT OF INFLATION

The distinguished British historian, Arnold Toynbee, reports that he has never studied a civilization whose currency didn't gradually peter out. This refutes the common belief that inflation is peculiar to the postwar period or to our times or our country. Historically, money has always been a bad investment. When you save dollars or dollar-equivalents—savings accounts, building and loan shares, life insurance cash values or government saving bonds—you are investing in a stock which, except for very brief interruptions, has been going down steadily for 175 years. Would you buy such a stock knowingly, especially if you had reason to

believe that it would go down even faster in the next 25 or 50 years?

This impressive historical fact, inflation, is probably the single most important factor for us to consider above all else as we go about our work of making a practical application of the principles of financial planning to the affairs of the average physician. That average physician, conscious of the necessity of providing long-term financial security for himself and his family, now tosses about on a sea of conflicting arguments and claims. Insurance men, stock brokers and sellers of more than 200 mutual funds all proclaim that they have the answer to the problem. Since, generally speaking, the only people who know about these things are the people who sell them, it is very difficult for our "average physician" to obtain expert information or advice which is not in some way biased . . . and biased advice is frequently worse than none at all.

The average physician must do two things: (1) he must provide adequate life insurance to care for his dependents if he doesn't live long enough to accumulate an estate, and (2) he must take care of the old man waiting down the road. Die with your boots on if you must, but let it be because you choose to, not because you are obliged to do so. These two problems are closely related, because if you spend too much of your income doing one part of the job, you may not have enough left to do the other part properly.

LIFE INSURANCE: HOW AND WHAT TO BUY

You must protect your family with enough insurance. Life insurance is a wonderful thing, but it can be terribly misused. *It was never originally intended* as an instrument for the building of an estate. Its purpose is to provide an estate if you don't live long enough to accumulate it yourself.

There are two basic classifications of life insurance—term insurance, and all other kinds. Term insurance is just protection; the "other kinds" all represent some combination of term insurance plus a savings account. When you buy an ordinary life policy, you pay the premium for term insurance plus an extra amount which the company is to put away for you with the understanding that they are to pay it back to you at age 96. The savings account part of the premium is so computed that, on a \$1,000 policy, it will have accumulated to \$1,000 at age 96. The chances of your reaching 96 are about one in 850,000—you can probably get better odds than

that in the Irish Sweepstakes! It is important, then, to understand that the policy provides that if you die before age 96 (even one day before) the company will pay to your beneficiary the face amount of the policy. *Included* in this face amount is your cash value. Only the *difference* between the face amount of the policy and the cash value is true insurance. That's the way an "ordinary life" policy works. A 20 payment life policy works the same way, except that the premiums are larger since you must crowd a lifetime of premium payments into the first 20 years. It still pays off the face amount at age 96.

During the years until age 96, the company will pay you 2½ to 3 per cent interest on your savings account. If you need to use some of that savings account, they'll lend it back to you at 5 per cent or more. If you protest that this is not equitable and tell them you have decided just to take your savings account out, the company will "punish" you by cancelling the protection entirely! You must take either the loan value or the cash value, and if you choose the latter, they cancel your policy . . . If you borrow on it, you'll still be saddled with high premium payments as well as the interest. . . . And your insurance will drop by the amount you borrow.

On the other hand, suppose you carry renewable term insurance instead of ordinary life, and have set aside the money saved on premiums. You can't borrow on your term policy, to be sure. But you can, in an emergency, use your savings—and pay no interest. Your fixed premium payments are much smaller, and your insurance protection is undiminished.

If you give the insurance company just the term insurance part of the premium and put the rest in a savings bank, by any given date in the future you will have more accumulated in the bank account than you would have in the insurance cash value. The insurance company pays out approximately 15 per cent of everything you pay in during your lifetime just for selling the policy, including 15 per cent of the savings account. The bank won't pay anyone for selling you the savings account. Interest will be added to your money—nothing taken from it. After five, or fifty-five, years, you will have more "cash value" accumulated in the savings bank. If you live, you are better off. But, what if you die? Have you sacrificed something? No, indeed. Your family will have all the insurance

and all the money in the savings bank. They'll have *both*—instead of the insurance company using your savings account/cash value to help pay off the claim. It would appear, then, that by buying term insurance *you* will be better off if you live, and *your family* will be better off if you die.

Insurance companies quite commonly reinsure large risks with other companies. When they do, they don't buy ordinary life, limited payment life, endowments or retirement income policies. When they are buyers of insurance instead of sellers, they buy term insurance.

Come to think of it, when you insure your house or your car, you give the insurance company just the cost of the protection. You don't give the company anything extra to hold for you. Why, then, when you insure yourself against dying before you have had time to accumulate an estate, should you give the life insurance company something extra to put aside in a savings account for you? Of course, you must have will power to save. If you need to have an insurance company take the money away from you, you should at least realize that you are paying a high price for your weakness.

We are agreed, then, that the cash value you get back from policies other than term insurance is merely a part of the extra premium that you need never have given them in the first place, and that the extra premium would work a whole lot more efficiently for you somewhere else.

Incidentally, insurance men make much of the fact that term insurance is not "permanent" protection, that it can be carried only until age 65-70. If the insurance man tells you that you should buy what he calls "permanent" protection instead of term insurance, ask him why a 20 year endowment which ends at age 50 or 55 is more "permanent" than a term policy which protects you until age 70. He is unquestionably honest and sincere in his advice, but bear in mind that his commission will be four times as much if he sells you his "permanent" policy, and ask yourself whether he is completely unbiased. Just keep remembering that the purpose of insurance is to give you *time* to accumulate an estate. If you live to age 65 or 70, you will have had the time, and unless you have been pretty clumsy in your financial planning, you'll have the estate. There'll be no point in your paying the high premiums which you would be required to pay thereafter for protection.

The great fortunes in this country were not built

by lending money at interest, even to insurance companies. These fortunes grew from an investment in the prosperity of American business and industry. More and more people realize this, and, in these years of change in many things, a great financial revolution is in progress.

Beardsley Ruml, the distinguished former chairman of the Board of the Federal Reserve Bank of New York, author of the Treasury's pay-as-you-go tax plan, and presently a trustee of the Committee for Economic Development, recently told an audience, "Insurance is not an efficient way to save except for those who find it difficult to save systematically in any other way. I favor placing the bulk of systematic savings in equity situations (common stocks). For most individuals . . . the diversified investment fund (mutual fund) is more suitable."

None of this takes into account the most deadly weakness of life insurance—its vulnerability to inflation. Insurance "guarantees" an income, but it gives no assurance of what that income will buy; one cannot eat those income dollars—one must exchange them for goods or services. In each of the past 15 years, the American dollar has lost on the average of 5 per cent of its purchasing power. Thousands of old people have had to go back to work because the "guaranteed income" from their insurance was no longer sufficient to pay their living expenses. The insurance companies who once advertised a retirement income of \$100 per month now offer \$300 a month. The trusting souls who paid in their hard-earned 1920-'40 dollars to get that \$100 income are now being paid off in what Al Smith once called "baloney dollars."

Many years ago, the Carnegie Foundation for the Advancement of Teaching created the Teachers Insurance and Annuity Association which was intended to function on a nonprofit basis as an insurance company for educators. But, in 1951, the TIAA reached this conclusion:

"Security in retirement poses a difficult problem when it means not only a sufficient annuity income in dollars, but also a reasonable income in purchasing power. Traditional methods of saving have fallen short of the goal of providing suitable purchasing power income."

As a result, the College Equities Fund was organized in the summer of 1952. Its purpose—to give teachers a chance to protect their surplus dollars

from inflation through a participation in a broad list of securities.

"Business activity has its ups and downs—the investor in common stocks must expect them—but in the long run an accumulating share in the growth and earnings of the major American industries seems a good way to assure a healthy retirement income, much as industrial growth helps assure the economic well-being of the nation as a whole."

(Incidentally, an effort is now being made by several insurance companies to introduce a "variable annuity," a contract which is simply a combination of term insurance to age 65 plus an investment in a segregated portfolio of common stocks held and managed by the insurance company. There is considerable opposition to the proposal on the grounds that the insurance companies, historically committed to investment in debt obligations, are not particularly well qualified to manage a portfolio of equities. Its opponents also contend that such a contract is actually a security and allowing it to be sold as an insurance policy, not subject to the various federal laws governing the sale of securities, would invite misunderstanding, if not misrepresentation. Actually, at best, it seems a clumsy duplication of the job now being ably done by the mutual investment companies. If the variable annuity is finally issued, it might be well for prospective purchasers to consider that it is essentially an investment and that an historical record of demonstrated investment skill is the one most important factor to look for when selecting investment management. The variable annuity will be in the experimental stage for a long time. It would seem prudent to defer entering into such a contract until those who offer it can point to concrete results instead of merely high hopes and good intentions.)

A good rule to follow, then, is to give the insurance company as little as possible to provide protection. Put the difference somewhere else. Completely divorce your protection from your savings and investment program. Buy low-cost term insurance which is either renewable every ten years, or which runs right through to age 65 or 70. Of the two, the first is more desirable. Companies and policies differ widely, so check carefully before you buy. But, be sure that the policy is renewable without examination and that it contains a disability

clause. A double indemnity clause for accidental death sounds great, but it's no bargain.

If you conclude that you want \$60,000 of protection, ask the company to issue it in four \$15,000 policies, each on an annual premium basis, with due dates spread out at three-month intervals. You'll have the convenience of paying your premium *quarterly*, but you'll pay the *annual* rate. (Did you know that you pay from 11 per cent to 22 per cent for the privilege of paying your insurance *quarterly*?)

WHAT TO DO WITH THE PROCEEDS

So much for the question of how to buy insurance—and what kind to buy. Next, you must decide how to leave the proceeds. You generally have two unhappy alternatives. You can leave the entire sum to the beneficiary in cash and take a chance on its being spent or unwisely invested. (Insurance companies report that 60 per cent of all life insurance which is payable in cash is dissipated within two years.) Or, to avoid that, you leave it with the insurance company under a settlement agreement which will result in your beneficiaries getting a miserably small rate of interest on the funds. Don't do either of these things. If you have enough insurance to make it worthwhile—say, \$35,000 or more—set up a life insurance trust with a bank. More about this, later.

This life insurance program based upon term insurance will cost you perhaps \$800, instead of the \$2,200 or more you'd pay for a more expensive form of insurance. You may appreciate this low premium in some possible future depression when you need pay only \$800 annually to keep your insurance estate intact.

Of course, if you are just going to spend the money you save by buying the inexpensive term policy rather than a higher premium form of insurance, you may as well forget this advice and do just as the insurance man suggests; the insurance company will at least take the money away from you. The whole purpose of this careful planning of your insurance is to free as much of your funds as possible to be put to work productively somewhere else. Don't defeat the program by not putting aside what you saved on the insurance premiums.

(The concluding part of this article will appear next month.)

NEWS FROM WASHINGTON

Eisenhower Asks More Private Financial Aid to Medical Colleges

President Eisenhower, in a major address October 22 to the National Fund for Medical Education, issued a call for business and community leaders, along with the general public, to help medical schools pay their bills. The President did not mention the administration's pending bill for federal construction aid to medical schools, although there is no indication it will not be pushed in the next session of Congress.

Implicit in Mr. Eisenhower's New York address is the need for increased voluntary efforts before turning to the federal government. "For government to take over all responsibility in this critical field would signal the onset of a grave inflection of our nation's spirit," the President told his audience of corporation executives, medical school educators and others interested in health matters.

The occasion was the awarding to Alfred P. Sloan, Jr., retired industrialist and president of the Alfred P. Sloan Foundation, of the Frank H. Lahey Memorial Award for lay contribution to medical education. The presentation was made jointly by former President Herbert Hoover; Dr. David B. Allman, president of the American Medical Association and Dr. John B. Youmans, president of the Association of American Medical Colleges.

Income Tax Reversal is Significant

Doctors practicing in groups, particularly if organized as an association, should recognize deep meaning of Internal Revenue Service's recent action in reversing itself. For the new position taken by IRS could mean that members of some of these groups may qualify for tax-deferred pension plans—something for which organized medicine has been campaigning for years.

"It is now the position of the Service that the fact that an association establishes a pension plan under section 401(a) of the Internal Revenue Code of 1954 corresponding to section 165(2) of the 1939 Code is not determinative of whether such organization will be classified as a partnership or an association taxable as a corporation.

"The usual tests will be applied in determining whether a particular organization of doctors or other professional groups has more of the criteria of a corporation than a partnership."

Those two paragraphs above constitute meat of latest expression by IRS. What they mean is that the government is abandoning the unrealistic position it has maintained for nearly two years and is preparing to make a larger number of medical group members eligible for tax relief of the type involved here.

Next step will be for the tax bureau to prepare and promulgate basic criteria to be used in testing whether an association of physicians is taxable as a corporation.

These developments have stepped up speculation on Congressional passage of Jenkins-Keogh bill, which would permit all self-employed physicians and dentists to participate in tax deferred pension plans.

If IRS maintains this policy, the effect will be to allow doctors forming an association (in line with IRS criteria yet to be established) to enjoy approximately the same annuity advantages they would under the Jenkins-Keogh and similar bills now pending in Congress. The sponsors would have to meet two tests: the association would have to qualify for the federal tax benefits, while at the same time avoiding the charge, under state law, of engaging in the corporate practice of medicine.

Current Methods Indorsed by Advisors on Medicare

AMA was involved in action taken by the citizens' group which is advising Defense conduct of the Medicare program. At annual meeting last June, House of Delegates went on record in favor of having Medicare operated on an indemnity basis, rather than full service, in those states which preferred former (such as Ohio). But on Friday, at its first meeting since last May, the advisory group stood by Defense and its advocacy of full service without exception.

Also, it supported Medicare policy of following local custom in matter of compensating anesthesiologists, radiologists and pathologists for profes-

sional services performed in hospitals. Many medical groups have written in to protest payments being made to hospitals under any circumstances.

OASI Study Council Named; Folsom Concerned Over Tax Rise

A 12 man advisory council has been named to review the financial position of the social security system and report back to Secretary Folsom. The council, provided for by the 1956 social security amendments, will review the status of the OASI trust fund and the new disability insurance trust fund in relation to the programs' long-term obligations. Scheduled payroll tax increases for 1965, 1970 and 1975 also will be studied. Mr. Folsom said the council could look into the cost of any new program (such as hospitalization at age 65), although studies of possible changes were not mentioned in outlining the group's duties.

Asked the position of the Department of Health, Education, and Welfare on the Forand bill for free hospitalization of the aged under social security, the secretary said there was no position, "but in a general way we are concerned with not getting payroll taxes to too high a level. Now payroll taxes are scheduled to reach $4\frac{1}{4}$ per cent for both employer and $6\frac{3}{8}$ per cent for the self employed by 1975. Also, these taxes are on gross earnings, with no deductions (as for income taxes)."

Health Office Abolished by Federal Civil Defense

Federal Civil Defense Administration has wiped out its health office. Under a reorganization scheme which became effective November 1 without public announcement, functions of FCDA's health unit have been scattered among "Operations Control," "Economic Requirements" and other reshaped branches of the agency, whose headquarters are in Battle Creek, Michigan. The health office itself, established a few years ago, was only a shadow of the high level medical service which was part of the original FCDA. Now it is abolished, at a time when AMA is urging an administrative upgrading and centralized responsibility for medical affairs in the agency.

Dr. M. M. VanSandt and Dr. Robert L. Smith, director and deputy director of health office, are to hold same titles in a newly created biophysical and

medical sciences office under the research and development service. Both are on detail from Public Health Service and it remains to be seen whether PHS, which is anything but happy over the kick downstairs, will approve the layout's continuation.

Active TB Declines 30 Per Cent in Five Years, But Still 250,000 Cases

Although active tuberculosis has declined 30 per cent in the last five years, the general control picture is not entirely reassuring. This is the report of Public Health Service and the National Tuberculosis Association on results of the only nationwide survey in five years. The check shows that despite intensive efforts for control, almost 40 per cent of the active cases are unknown to health authorities, and these people are not receiving treatment. ("Unknown" cases are estimated on the basis of x-ray survey findings.) Other findings—In the five years there has been no decrease in number of persons who are or have been ill with the disease, and there are still about 250,000 persons known to have tuberculosis in its active form. The most encouraging phase of the report is that active cases have dropped from 350,000 to 250,000 and inactive cases requiring supervision of health departments from 600,000 to 550,000.

Increasing Flu Incidence Expected Until Early January

Surgeon General Burney's advisory committee on influenza believes there will be increasing incidence of Asian influenza until early January, when the total of cases will level off, then start to decline. In announcing the committee's forecast, Dr. Burney made these additional points:

1. Doubling of the potency of the vaccine was made possible because the virus now is growing "almost profusely" for manufacturers.
2. Substantial protection is obtained from current vaccine (200 units), and people who already have been vaccinated should not be vaccinated again at this time with the new vaccine (400 units), in view of vaccine shortages. The new vaccine is expected to be between 10 and 15 per cent more effective than the old.
3. While increasing the potency will slow production about one-third, processing has been stepped up to such a degree that over 80,000,000 doses

will be available by the end of November, an amount far in excess of original goals.

4. One flaw in the vaccination campaign is failure to vaccinate more patients whose conditions make them high medical risks.

5. A number of controlled tests suggest that "constitutional symptom" reactions to the vaccine appear only about in four per cent of those vaccinated.

Asian Flu Vaccine Potency Doubled: Faster, Higher Immunity

Surgeon General Burney of Public Health Service announced that it is now possible to double the potency of Asian influenza vaccine, and that the more potent doses will significantly increase not only the degree of immunity but the rapidity with which immunity is achieved. Acting on recommendations of an ad hoc advisory committee to the PHS Division of Biologics Standards, he has asked manufacturers to make the change as soon as possible, but not later than December 1.

Because of more experience with the particular virus strain, and because manufacturing processes have improved since the first vaccine was released in August, it is understood that strengthening of the vaccine will mean little if any delay in production.

Doctor Fees Below Other Health Costs

A report in the *Monthly Labor Review* on medical care costs in the cost of living index notes that in the past 20 years hospital costs have risen sharply in contrast to physician's fees. The article by a Bureau of Labor Statistics employee lists these increases between 1936 and 1956: hospital room rates, 264.8 per cent; dentists' fees, 82.1 per cent; general practitioners' fees, 72.8 per cent, and surgeons' fees, 59.5 per cent. In the same period, medical care costs generally have lagged behind costs for food, personal care other than medical and clothing. The report makes this observation: "With the higher level of living attained in 1950, relative expenditures for medical care tended to increase as incomes increased, as is usually true of items considered as 'necessities' in the family budget. The fact that this pattern has begun to appear in the spending of workers' families indicates the high order of importance they place on medical care."

Editors Push for Doctor-Hospital Press Guides

More than 60 editors of Associated Press newspapers in Illinois, meeting in Chicago's Palmer House recently, spent nearly two hours discussing doctor-hospital press guides and then adopted a resolution urging establishment of such codes at the local level.

The editors' meeting, patterned after a similar AP session in Crookston, Minnesota, on September 15, brought together top-ranking newspapermen from all over Illinois.

A panel discussion centered around doctor-hospital press relations. The medical side of the panel was represented by Dr. Robert E. Heerens, Rockford, who until a short time ago served three years as chairman of the public relations committee of the Winnebago County Medical Society; John L. Bach, director of AMA press relations, and Delbert L. Price, administrator of Children's Memorial Hospital in Chicago.

After the discussion and a question-and-answer period, the editors held a business meeting and adopted the following resolution, which was later sent via AP wires to every member newspaper in the state:

"Whereas: Model codes for the guidance of doctors, hospitals, and newspapers in reporting news affecting medical organizations are now in operation at Decatur, East St. Louis, and Urbana;

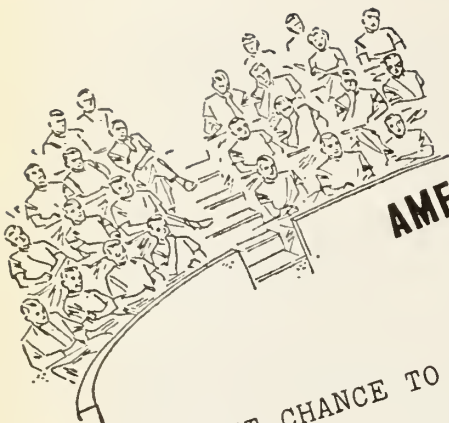
"And Whereas: These guides have proved beneficial to the general public;

"Now, Therefore: For the increased mutual benefit of the public, the medical profession, and newspapers, the Illinois Associated Press Editors Association urges that its members cooperate with physicians and hospitals toward the establishment of doctor-hospital press relations guides in every county in the state."

Illinois has 102 counties.

Such a guide might well be established in Connecticut. (Ed.)

Social security has been changed many times in the 22 years since the original law was enacted. The size and variety of benefits, the tax rates, the tax base, coverage—all have been radically changed. There is no reason to believe that another 22 years will not see just as radical changes.



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Film Service Being Planned for Local Medical and Community Groups

A film service is being planned by the Society's Committee on Public Relations for county and local medical associations and community groups.

It is anticipated that the service will go into full operation early in 1958, but arrangements already have been made to provide a limited service until the end of this year, according to a recent announcement by Dr. Harry C. Knight, Public Relations Committee chairman.

The service will operate out of Hartford and certain films concerning medical associations and their services will be available for immediate scheduling. Other films will be obtained from national sources to fill specific requests made by medical or other organizations sufficiently far in advance of meetings to permit such planning.

Notices concerning films available will be sent to officers and program chairmen of medical associations early next year. At the same time a new Speaker's Bureau booklet and notices of films available will be sent to program chairmen of community organizations and service clubs.

Plans include furnishing of films for certain subjects listed in the Speaker's Bureau booklet and these can be introduced by physician speakers for use prior to or following their presentations.

The service will be provided at a reduced charge and will include complete projection service, with films, screen and projector supplied by an operator from the film agency.

Requests for use of the service should be directed to the offices of the State Medical Society.

New County Association Booklet Announced

A new publication containing results of a 1957 survey of the increased activities of county medi-

cal associations has been announced by the Council on Medical Service of the American Medical Association.

The booklet will include information on all types of county medical service programs ranging from community emergency call plans, grievance committees, and fee schedules to life insurance programs for members, attendance at association meetings and dues.

It is planned to mail copies of the booklet directly to all county associations. Additional copies may be obtained through the offices of the State Medical Society.

AMA Plans New Exhibits for 1958

The Bureau of Exhibits of the American Medical Association has announced major plans for 1958 aimed at reaching more Americans with up-to-date health information.

A feature of the program will be a new exhibit "How We Breathe," which will be ready for bookings early in January. The exhibit will include a three dimensional model of the organs involved in breathing. Other features include actual preserved human lungs, a unit to demonstrate the mechanism of breathing and the part played by the diaphragm and rib cage, and a section showing the exchange of oxygen from the lungs to the blood and carbon dioxide from the blood to the lungs.

Two other exhibits also are well along in the planning stages for next year: (1) the brain and nervous system, featuring a human brain embedded in plastic and (2) the endocrine system. Further details will be announced later.

Small editions of the popular "Life Begins" exhibit also are being built, incorporating most of the information in the large exhibit but displaying only one fetus embedded in plastic.



FAIRFIELD COUNTY MEDICAL ASSOCIATION SPONSORS EXHIBIT AT DANBURY FAIR

This picture of a public service exhibit sponsored by the Fairfield County Medical Association was taken at the Danbury Fair October 6.

The exhibit, titled "You and Your Medical Care," was provided by the American Medical Association and physicians were present during the 10 days of the fair to answer the questions of fairgoers. Health publications were presented to interested viewers of the exhibit and the committee also provided cold spring water for thirsty fair visitors.

The exhibit was a project of the Association's Committee on Public Relations, under direction of Dr. M. David Deren, Bridgeport, chairman. It was the third annual health education project to be sponsored by the Association at the Danbury Fair.

The exhibit committee of physicians was

assisted by a committee from the Woman's Auxiliary to the Fairfield County Medical Associations. Members of the Auxiliary who served during the fair were: Mrs. George R. Eckert, Mrs. William Sinton, Mrs. John D. Booth, Mrs. Michael A. Yoburn, Mrs. Henry Blansfield, Danbury; Mrs. John Jovell and Mrs. Harold Patterson, Redding; Mrs. Joseph Cherry and Mrs. C. King Hamilton, Brookfield; Mrs. Edwin R. Connors and Mrs. Ellwood C. Weise, Bridgeport.

Physician members of the committee were: Drs. Thomas P. C. Jameson, Marjorie E. J. Shafto, Michael Yoburn, Paul Kunkel, Isadore L. Amos, Jack Levin, Walter I. Gryce, William M. Stahl, Jr., William A. Sinton, John D. Booth, Robert G. Miller, all of Danbury.

OUR MEDICAL WORLD

France

THE SUPPLY OF PHYSICIANS

The employment situation in the medical sector in France is characterized by an intermediary position. Between countries of an equal distance having a high and low medical population, there is one practising physician for every 1,000 inhabitants.

Taking into account the following hypotheses: Influence of an expected increase in the population; Influence of the rise in the Standard of Living on Medical Welfare, Social Medicine, Administrative Medicine, Scientific Research and the influence of technical progress; Professor Magnin estimates that in 1961, the Medical Corps will probably be 47,000 in number, a number surpassing by very little the normal possibilities of employment.

As the result of a calculation based on a study of university and professional statistics (repartition by age) we arrive at the number of 51 to 52,000 practising physicians, numbers surpassing by 2 to 3,000 the optimum number of physicians calculated following the hypothesis of an increase in the population and the Standard of Living. These estimations bring us to the point that the actual number of graduates is too high. The Board of the Medical Association has insisted for 10 years that the recruitment and the formation of medical students should be the object of a plan established in harmony with the needs of the nation. In this connection (always according to Mr. Magnin) there has always been much insistence on the poor repartition of physicians in France; this is explained largely by economical reasons and coincides with the unequal geographical repartition of the national income.

These conclusions more moderate than those generally advanced by the Medical Board show us that the openings in medicine are not yet exhausted, and that the sanitary equipment of the country (for private practitioners as for salaried ones) can yet offer notable ameliorations.

SOCIAL SECURITY

Strenuous campaigns have been carried on by the Social Security funds and the labour organizations. These have been opposed by the campaigns of the doctors which were just as strenuous.

The firm stand taken by the doctors with the introduction of the proposed law to Parliament has resulted in counter-proposals from former Minister Lafay of the political party M.R.P.; Mr. Soustelle, former Minister; Mr. Gaillemain and Mr. Roclore. While these counter-proposals did not satisfy the medical profession, they did show considerable improvement over the Glazier plan.

Special mention must be made of the reaction of the medical profession in the large cities, particularly Paris, where there is strenuous competition with the public clinics.

The medical profession had serious objections to the project that would reduce the importance of the "Public Health Ministry" by converting it into a simple Secretariat of State. The doctors are of the opinion that the control and improvement of public health in the modern state requires a responsible organization that has extensive power to act. This can only be achieved by a Ministry with full prerogatives.

A meeting of general practitioners, attended by representatives from several European countries was held September 1, 1956 at Evian; a similar meeting is scheduled at Vichy, September, 1957. This group, through its leaders has emphasized its desire to remain within the framework of The World Medical Association.

The VIIth Congress of the Rural Medicine Association was held June 21, 1957 at Mont-Dore. Its discussion centered upon the training essential for rural doctors and the special requirements of the rural laboratory.

The Doctor's Retirement Fund, having received an appeal to double the amount of the pension it pays the doctor, has asked each doctor to contribute a percentage of his professional income in addition to the fixed fee he pays into this fund.

On September 22, 1956, an Interministerial Committee was named to study amendments in the medical education and hospital structure. The Seine Departmental Council of the Ordre des Médecins has published a study that stresses the desirability of maintaining the character of French medicine and not putting it on the "level" of foreign medicine. Among the suggested amendments, there is one to

create a third stage of studies for young doctors who wish to prepare themselves for teaching, research work or a specialty. This would simply be the legalization of a practice already carried out.

A Committee of Friends of The World Medical Association has just been established.

Belgium

SOCIAL SECURITY

In Belgium, the Social Security Organization is comprised of several separate "mutualities." As in France, the Belgian Health Minister has tried to regiment and restrict the free practice of medicine. The Belgian doctors have set a remarkable example of professional unity by establishing a "National Doctor's Service" which within a few months of its founding had 65 per cent of the doctors, general practitioners as well as specialists, in its membership. The University and the Academy of Medicine have supported the doctors fully.

A Defense Committee has provided the government with the 10 requirements set forth by the doctors in order to resume further negotiation with government representatives. The government considers asking Parliament for authority to subdue the medical profession. The battle continues and its ultimate conclusion will depend upon the degree of unity maintained by the doctors.

Great Britain

THE NATIONAL HEALTH SERVICE AND THE DOCTORS

To understand the difficulties now facing the British doctors, it is necessary to go back to the days in 1948 when the National Health Service (N.H.S.) was established and consider the agreements reached at that time between the government and the leaders of the British Medical Association.

Two Commissions were established, both known as "the Spens Committee," to provide regulations for fair remuneration of the general practitioner on the one hand and consultants, specialists and hospital doctors, on the other.

With some delay, these two Committees issued their conclusions, noting that it was difficult to quote figures in accord with the 1948 cost of living, and therefore, based their conclusions and figures on 1939 economic values with these rates subject to a coefficient of increase betterment factor. Remuneration was to be made from a central fund at a fixed fee for each patient registered with each

doctor.

They estimated that this remuneration system would insure, in the case of the general practitioner, 50 per cent of all doctors between the ages of 40-50 years engaged in general practice, a net income of at least 1,300 pounds annually, with a minimum income of 1,000 pounds and the understanding that a certain percentage of the doctors would earn 1,600-2,000 and even, for a small proportion, 2,500 pounds.

The Spens Committee for consultants and specialists published its conclusions even later than that for general practitioners. It emphasized that doctors in this category should not be handicapped with economic problems or tempted to seek work outside the system. It recommended that the annual remuneration should be as high as 5,000 pounds.

However, and this is very important, the Spens Committees specified that adjustments must be adopted in the event that the current circumstances were altered and this statement was confirmed by several ministerial disclosures.

The coefficient of increase applicable in 1948 as compared to 1939 was estimated at 85 per cent; in 1950-1951 at 100 per cent. These increased coefficients were confirmed by Mr. Danckwerts, designated arbiter for a common agreement.

Because of the delays, however, this decision was not applied to the specialists. Whether they liked it or not, in April, 1954, these specialists had to accept a transactional agreement which was in no way satisfactory to them.

Due to the increased cost of living, and increased salaries and wages between 1951 and 1956, the doctors issued two statements in which they justified their request for a 24 per cent increase based upon historic, legal, administrative and ethical statements.

This request issued on August 1, 1956 has not yet—on the date this was written—been acted upon as the British government no longer considers itself to be bound by the recommendations of the two Spens Committees. A few months ago, the British doctors issued a threat of mass resignation from the National Health Service. The threat of a mass resignation resulted in March, 1957 in the Prime Minister increasing by 10 per cent the lowest salaries of the hospital doctors and a Royal Commission being established to study the whole problem. Naturally, the British doctors are not satisfied.

The foregoing reports on Social Security were presented at the 11th Annual Congress of World Medical Association, Istanbul, Turkey, October, 1957.

Health Insurance in West Germany

According to the *New York Times* West Germany is debating what to do with a health insurance system that now has a "surplus" of physicians.

Four of five West Germans are insured under public health insurance—23,800,000 directly and 14,200,000 indirectly as family members. An additional 10,200,000 persons are enrolled in private health insurance, of a total population of about 50,000,000.

The health insurance apparatus does not directly employ the physicians. Instead, private practitioners are paid a fixed fee for each health insurance patient seen. The fees are low, and nearly every private practitioner takes on a huge patient load.

But the medical doctor's title rates high and medicine is the most populated field in West Germany's universities. Also, the flight of professional men from Communist East Germany has added to the ranks of physicians.

West Germany has 2,000 public health insurance societies with total staffs of 50,000.

Doctors Allege Atrocities in Cuba

The 11th General Assembly of the World Medical Association convened at Istanbul, Turkey, recorded its profound shock at the allegations brought before it with reference to recent events affecting the medical profession in Cuba. The General Assembly reiterated the principles contained in its Declaration of Geneva and its Regulations governing the activities of doctors during armed conflicts, namely:

that doctors must give their first consideration to the health of their patients;

that they must not allow reasons of religion, nationality, race, party politics or social standing to intervene between them and their duty to their patients;

that doctors must practice inviolable secrecy on whatever is confided in them by their patients, and that these principles should be recognized and observed by all governments. No doctor should ever suffer any penalty because he has rendered aid to the sick and wounded.

The World Medical Association lends its full moral support to the doctors of Cuba in their efforts to adhere to these basic humanitarian principles.

The General Assembly directed the Council to obtain further information and if possible evidence

of specific violation of these principles; draft a statement on the subject for all national medical associations and keep them informed from time to time of developments pertaining to the freedom of doctors to practice their humanitarian activities in the Republic of Cuba.

Directed the Secretary General to arrange for a committee to visit Cuba with full authority to conduct an on-the-spot investigation and directed that all information received be transmitted to the United Nations with a request that this organization be invited to conduct its own investigations as to the allegations.

Since the meeting in Istanbul news has reached this country that two members of the Cuban Medical Association have been murdered for having ministered to insurgents wounded in fighting the regime of President Batista. This is a serious situation and affects the status of physicians the world over who attempt to carry out their professional activities freely. The free nations of the world accept and support the principal that belligerents, whether international or national, are entitled to medical care without discrimination or fear of reprisal.

THE DOCTOR'S OFFICE

Donald B. Alderman, M.D., D.A.B.S. announces the removal of his office to 186 Sherman Avenue, New Haven, for the practice of general surgery and the diagnosis and treatment of peripheral vascular disease.

John Burbank, M.D. and Michael Esposito, M.D. announce the association of Herbert Friedman, M.D. with them in the practice of radiology at 236 West Main Street, Meriden, and 26 Fair Street, Wallingford.

Julian S. Kaiser, M.D. announces the opening of an office for the practice of internal medicine at 85 Jefferson Street, Hartford.

Harvey Pastel, M.D. announces the opening of an office for the practice of surgery at 627 Main Street, Manchester.

Joseph Weiner, M.D. of 100 Whitney Avenue, New Haven, announces the removal of his offices as of January, 1958 to 256 Edwards Street, New Haven. Practice will be limited to pediatric allergy.

AMA Committee Prepares Poisoning First Aid Rules

Speed in starting first aid measures is essential after accidental poisoning, according to the American Medical Association's Committee on Toxicology.

First aid measures are aimed at helping to prevent absorption of the poison and must be started at once, the committee said in a new pamphlet issued as a guide for the public in the treatment of accidental poisoning. The pamphlet's instructions are reprinted in the current (October 12) *AMA Journal*.

When poisoning occurs, one person should begin treatment while another calls a physician. When only one person is available to give treatment, he should call a physician first if the poison is a corrosive or a petroleum product. A corrosive may be an acid substance such as a toilet bowl cleaner or an alkali such as household bleach.

When a non-corrosive poison is swallowed, vomiting should be induced and then a physician called. Vomiting can be started by giving the patient milk, plain water, or warm salt water, or by placing the blunt end of a spoon or the finger at the back of the patient's throat.

Vomiting should not be induced if the patient is unconscious, in a coma, or in convulsions; has swallowed petroleum products, such as kerosene, gasoline, or lighter fluid, or has swallowed a corrosive, such as a rust remover, styptic pencil, lye, washing sode, or ammonia water.

Symptoms of corrosive poisoning are severe pain, burning sensation in mouth and throat, and vomiting.

When retching and vomiting begin, the patient should be placed face down with the head lower than the hips. This prevents the vomitus from entering the lungs and causing further damage.

In the case of inhaled poisons, the patient should be carried to fresh air immediately, his clothing loosened, and artificial respiration begun if breathing has stopped or is irregular. The patient should be kept warm and as quiet as possible.

With skin contamination, the skin should be drenched with water. A stream of water should be held on the patient while removing his clothes. Rapidity in washing is most important in reducing the extent of injury. When the eyes are contaminated, they should be washed immediately with a gentle stream of running water. Chemicals should

not be used, since they may increase the extent of injury.

Chemical burns also should be washed with large quantities of running water, except those caused by phosphorus. Ointments, greases, powders, and other drugs normally used for burns should be avoided.

Alcohol should not be given in any kind of poisoning.

The first-aid instructions may be obtained by writing to the AMA Committee on Toxicology, 535 North Dearborn Street, Chicago 10, Illinois.

Educational Council for Foreign Medical Graduates

After nearly three years of planning, the Educational Council for Foreign Medical Graduates has placed an "open for business" sign on the door of its offices in suburban Evanston.

The council, which will carry out a detailed and comprehensive program for evaluating foreign medical school graduates, has offices in the Orrington Hotel in Evanston. The executive director is Dr. Dean F. Smiley, Chicago, former secretary of the Association of American Medical Colleges.

It was decided three years ago that some form of evaluation service should be established within an independent agency whose affairs would be directed by a board of trustees designated by four cooperating organizations, the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, and the Federation of State Medical Boards of the United States. For the next two years, the council will be supported by the four sponsoring agencies, the Kellogg Foundation and the Rockefeller Foundation.

The council, incorporated in the State of Illinois, will be administered by a 10 member board of trustees—two representatives from each of the four sponsoring agencies and two persons representing the public at large, one named by the U. S. Department of Defense and the other by the U. S. Department of Health, Education and Welfare.

The president of the board is Dr. J. Murray Kinsman, dean of the University of Louisville School of Medicine.

Dr. Smiley said the council will distribute to foreign medical graduates around the world authentic information regarding the opportunities and

difficulties involved in coming to the United States on an exchange student visa in order to take training as an intern or resident in a U. S. hospital, or coming on an immigrant visa with the hope of becoming licensed to practice.

The council will make available to properly qualified foreign medical graduates, while still in their own country, all information on how to obtain certification. This involves a three-way screening process:

1. The council will certify that a student's educational credentials have been checked and found meeting minimal standards—18 years of formal education, including at least four years in a bona fide medical school, but excluding hospital training.

2. The council will certify that knowledge of English has been tested and found adequate for the needs of an internship in an American hospital.

3. The council will certify that the general knowledge of medicine, as evidenced by passing of the American Medical Qualification Examination, is adequate for assuming an internship in an American hospital.

The council also will provide hospitals, state licensing boards, and specialty boards, which the foreign medical graduate designates, with the results of the three-way screening. It also will accumulate and publish each year complete data regarding the numbers and placement of foreign medical graduates in this country.

FROM OUR EXCHANGES

Relman in a paper presented before the regional meeting of the American College of Physicians in New Haven titled "Current Status of Aldosterone in Clinical Medicine" brought out the fact that with the discovery of the potent adrenal mineralocorticoid substance, aldosterone, new insights have been provided into the mechanisms of a great variety of clinical syndromes.

1. Primary aldosteronism: Excessive production of aldosterone by benign adenomata or bilaterally hyperplastic glands has been shown to be responsible for the production of a syndrome of hypertension, potassium deficiency and alkalosis, and nephrogenic diabetes insipidus. Removal of the tumor or resection of both adrenals will correct the potassium wasting defect and sometimes, but not always, the associated hypertensive disease.

2. Hypoaldosteronism: A new syndrome apparently resulting from a defect in the mechanism responsible for aldosterone release has been identified. Its chief characteristic appears to be hyperkalemia and a slight tendency to sodium wasting on a low-sodium diet.

3. Secondary aldosteronism: Increased production of aldosterone appears to occur in almost all clinical syndromes associated with edema and sodium retention. The etiologic role of hormonal imbalance in

the production of edema, however, remains uncertain. Certain physiological observations concerning the salt retaining effects of aldosterone and other mineralocorticoid substances are presented. These would suggest that clinical edema is rarely, if ever, the sole result of hormonal imbalance.

* * * *

Trustee, the journal of the hospital governing boards, in its July, 1957 issue contains an article headed "By-Products of Accreditation in the Smaller Hospital." Two suggestions are made by the author which are worthy of note (thought and action, the article reads). First, that the joint commission should give attention to the medical record difficulties faced by the smaller hospitals without interns or residents, and second, that the medical societies should take a more active role in persuading their membership of the physicians' responsibility for meeting accreditation standards.

* * * *

A recent issue of *American Association of Industrial Nurses Journal* contains several articles on different phases of highway safety. The lead article is by Governor Ribicoff, chairman of the Governors' Conference of the Highway Safety Committee, and bears the title, "An Open Letter to the Nurse in Industry Regarding Highway Safety."



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NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive $\frac{1}{4}$ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Nichols, R. L. and Finland, M.: *J. Clin. Med.*, 49:410, 1957.



OBITUARIES

John Henry Bumstead, M.D.
1897 - 1957



John Henry Bumstead, or "Jack" as he was affectionately known to his many friends, was born in New Haven, Connecticut, on May 17, 1897. His death occurred at the Memorial Unit of the Grace-New Haven Hospital on the morning of July 29, 1957. In the sixty intervening years he had done little perhaps to engrave his name indelibly in the annals of medical science, but he had won a reputation any physician would envy—that of "a good doctor." He had the qualities that one associates with the old-time family physician. He was a keen clinician, a quiet man of great modesty, unselfish, thoughtful, unassuming, sympathetic, with a quick sense of humor, an inexhaustible fund of amusing stories, and a generous endowment of common sense both in medical and human affairs. The deep devotion of his patients and many friends is a more moving tribute to him as a physician and a man than any I can pay him here.

John Bumstead was the son of Louetta Ulrich and Henry Andrews Bumstead, the latter professor of physics at Yale for many years. Jack attended the Hotchkiss School and had the advantage of a year's

study in Munich, Germany, before entering Yale. His education was interrupted by the First World War in which he served as a lieutenant in the Air Corps. After securing his B.A. in 1919, he attended the Johns Hopkins Medical School, graduating in 1923. He remained at the Hopkins for five years, first as an intern, then assistant and finally instructor in pathology. In 1928 he returned to New Haven and served as assistant resident, then resident, at the New Haven Hospital. In 1930 he hung up his shingle and for the next twenty-seven years practiced medicine in New Haven, retaining a clinical affiliation with the School of Medicine (he was Associate Clinical Professor of Medicine at the time of his death) and serving as assistant physician and medical examiner of the Department of Health of Yale University from 1930 on.

These appointments were interrupted in World War II by three and a half years in the Army Medical Corps during which time he was attached to the 39th General Hospital and stationed at New Zealand (one year) and at Saipan (two years). He served as assistant medical officer, then as chief medical officer, of the Yale Unit, and held the commission of lieutenant colonel when discharged. During these years he acquired the reputation of being an anchor to windward for the whole Unit, for his imperturbability and good humor were great enough to counteract even the frustrations of Army red tape, the confusion of battle, and the short patience and frayed tempers of colleagues working under terrific pressure. For his outstanding service he was awarded the Bronze Star; the citation is as follows: "Lieutenant Colonel John H. Bumstead, Medical Consultant, Western Pacific Base Command, during the period May 1945 to August 1945 greatly aided in the diagnosis and proper treatment of hundreds of medical casualties evacuated from forward areas. In addition to his duties as chief of the Medical Service, 39th General Hospital, he worked long and diligently assisting and advising in the care of medical cases in other hospitals. His exceptional ability in planning the internal structure of medical service for organizations in the Western Pacific Base Command has aided materially in the overall treatment of medical

cases throughout the area. His administrative, professional, and executive ability reflect great credit on the Medical Department of the Army of the United States."

Just before he entered the service he had occasion to stake his reputation on the first clinical trial of penicillin in this country. During the many years that Bumstead acted as my personal physician, I only once heard him mention another private patient by name; this was in March, 1942 when he wished to obtain some of the *Penicillium* mould which was said to combat blood-stream infections in man. At the time I happened to be ill in the New Haven Hospital occupying a room next to another of his patients who for a month had been going steadily downhill as the result of a hemolytic streptococcus infection. I knew that Dr. Perrin Long, as chairman of the National Research Council Committee of Chemotherapy, had a small supply of impure extract, 5 cc. of which he sent by air mail to Bumstead. This successful trial of penicillium actually established antibiotic therapy on a firm world-wide basis, an epic contribution for which Bumstead with characteristic modesty refused to take any credit, referring it all to Sir Howard Florey of Oxford who was responsible for its refinement for clinical use.

Jack Bumstead published few scientific papers, but no one was more conscientious than he in following the publications of others. He went almost daily to the Yale Medical Library to read the newly arrived journals, and he evinced lively interest in all library affairs as one of the first Trustees of the Yale Medical Library Associates. He also served medicine in Connecticut through his long service and inestimable contribution as a member of the Connecticut Medical Examining Board.

His interest in the cultural background of his profession led to his being elected in 1952 to the Beaumont Medical Club whose meetings he attended as faithfully as the demands of his practice permitted.

In 1924 Dr. Bumstead married Katherine H. MacAlister of Belair, Maryland, and they had one son, John Robinson Bumstead, both of whom survive as well as a sister, Mrs. William A. Stevenson of Oberlin, Ohio, wife of the president of Oberlin College, and an aunt, Mrs. Spencer Ewing of Oberlin.

The Bumstead family had a summer place at Noank, Connecticut, and in his childhood Jack thus became fond of the sea and of sailing. He had

recently built a summer residence of his own at Sachem Head, Guilford, where he had a boat in which he had much pleasure and relaxation. Associates have remarked on his knowledge of both birds and shells—obviously an extensive knowledge but always revealed in an off-hand way.

If you ask his friends to characterize Jack Bumstead, the first thing they will tell you is that he had no enemies, that he was never aggressive or ambitious for himself, that he wanted only to do his own job of being a good physician, that he did not realize his own potentialities. And all of them will mention his broad medical knowledge so quietly and modestly manifested, his kindness, his stories, and his serenity which was such a steadying force in crises, whether those of others or his own. In these real but often intangible ways Jack Bumstead enriched both medicine and the lives of his friends, an enviable achievement for any man in a lifetime.

John F. Fulton, M.D.

Frederick G. Beck, M.D.

1874 - 1957



Frederick G. Beck was born in New York City October 12, 1874 and died suddenly in a Nursing Home at Gabriels, New York on August 23, 1957.

Fred moved to New Haven with his family when a boy. He graduated from New Haven Grade School and Hillhouse High and entered Yale with the Class of 1899, but withdrew at the end of two

years to enter Yale Medical School, graduating with M.D. degree in 1903. He interned at New Haven Hospital 18 months, New York Lying-In Hospital four months, and St. Mary's Children's Hospital New York three months.

On June 28, 1905 he married Gretchen Fresenius and on his wedding trip went to Europe where he studied for a year, chiefly in Germany and Vienna. Returning to New Haven in 1906 he opened office for the practice of medicine including obstetrics and surgery and was a member of the staff at the Hospital of St. Raphael.

A son, Frederick Beck, was born June 14, 1906, and graduated from Yale Medical School in 1928. For many years he has been Medical Director of Ray Brook State Tuberculosis Hospital, Ray Brook, N. Y. A daughter Margaret was born December 7, 1907. She married Hannibal Hamlin, M.D., Yale 1936, now a neurosurgeon in Providence, R. I. There are six surviving grandchildren. Mrs. Beck died in 1931.

At Yale Fred distinguished himself on the track team in 1900 with a shot put of 44 feet, 3 inches in the Intercollegiate Association of Amateur Athletics of America. In 1901 he won the United States Championship with a shot put of 42 feet, 11¼ inches. In 1902 at the Intercollegiate 4 A Meet he won the shot put with 44 feet, 6¼ inches and in 1903 won the shot put with 46 feet, a record which stood for many years. He also was a guard on the Yale football team of 1902 which won the Ivy League Championship.

Fred served as captain on the staff of the Second Company of Governors Foot Guard. He was a member of Mory's and the Yale Track Association. He was an active member of New Haven City, County and State Medical Associations. He was a long time member of New Haven Country Club where he was an ardent golfer and after the 19th hole could always be relied on to chime in with his beautiful tenor voice. One of his favorites was the "Beautiful Land of Peru," always to be remembered by his friends. He also was a Mason and Knights Templar.

In 1951 Fred retired from practice because of physical disability. For six years he had lived with his son Fred at Ray Brook State Hospital where he had been failing but never bedridden. His death came suddenly while his son was away on a European trip.

Those of us who knew Fred well, will always

remember his smiling face, his genial disposition, his athletic prowess in track and golf and above all his fine tenor voice which resulted in forming many friendships.

Ralph W. Nichols, M.D.

Carl C. Chase, M.D.

1900 - 1957



Dr. Carl C. Chase was born in Bennington, Vermont in November of 1900. His early education was received in the public schools there and his academic and medical courses were followed at the University of Vermont. Following his graduation in medicine, he interned at the Waterbury Hospital, Waterbury, Connecticut. On the completion of his training there, he entered into the general practice of medicine in Chester, Connecticut. It was there that he met and married Dorothy Collins of Cobalt, Connecticut and to this union were born three children, two girls and one boy.

Carl's death came as the result of a coronary thrombosis sustained just as he had completed a cataract extraction on the left eye of a patient. Just one year ago he had suffered a like attack and by a strange quirk of fate, it had followed a cataract operation on the right eye of this same patient.

In addition to his bereaved wife, he leaves his mother, Mrs. Hugh Chase of Bennington, Vermont; a son, Donald, of Cromwell, Connecticut; and two daughters, Mrs. Walter Hatch of Cranford, New

Jersey, and Mrs. Alvin Barnes of Syracuse, New York; two sisters, Mrs. Damon Biddle of Middletown, Connecticut; and Mrs. Jerome Spurr of Ankara, Turkey; and one brother, Earl Chase of Bennington, Vermont. Also seven grandchildren.

Carl Chase was a gifted man. He was endowed with a keen, analytical mind and a manual dexterity which made him a splendid operator. These faculties, compiled with sound judgment and a pleasing and compassionate personality could not but spell success for him in his chosen field. This success he accepted as a sort of trust from a kindly Providence and so was always ready and willing to help those less fortunate. There was no appeal for funds, be it from his Alma Mater, the local hospital, Community Chest or whatever deserving group, that he was not in the forefront of generous givers.

For the undersigned, who has penned this inadequate tribute, the severing of a professional relationship which has spanned over a quarter of a century leaves a wound which only the alleviating hand of time can heal. In bidding him this last farewell I would like to paraphrase the lines spoken at his grave by the Reverend Ralph Christie:

"Warm summer sun, shine friendly here.
Warm Western wind, blow kindly here.
Green sod above, rest light, rest light
Good-night, dear friend, good-night, good-night."

William M. Joyce, M.D.

Donald Bernard Moore, M.D.

1905 - 1957

On September 3, 1957 death came suddenly, although after an illness of some years' duration, to Dr. Donald Bernard Moore at St. Raphael's Hospital where he was a staff member.

Dr. Moore was born and educated in New Haven. He graduated from Hillhouse High School in 1923. He attended Holy Cross College and graduated in 1927, and then entered Tufts Medical School from which he obtained an M.D. degree in 1935. He interned at St. Joseph's Hospital, Providence, Rhode Island, and St. Elizabeth's Hospital, Brighton, Massachusetts, in 1936 and 1937.

Dr. Moore opened his office at 588 Howard Avenue in 1938 and had practiced on the "Hill" since that time except for the interruption of three years for war service. He served in the United



States Navy in World War II with the rank of lieutenant commander.

Dr. Moore served on the staff of St. Raphael's and was a member of the Department of General Practice. In the community of Greater New Haven he commanded a wide range of practice during the years. He was a popular and competent family physician. Besides his general practice he was associated with the Supreme Physician of the Knights of Columbus. He did industrial medicine at the Sperry and Barnes plant in New Haven. He was a member of the local medical societies, as well as the State and national societies, and was a member of the Connecticut Chapter of the American Academy of General Practice. He was a member of the Association of Railroad Physicians, the Military Order of World Wars, and the Catholic Physicians' Guild.

Dr. Moore's expanding general practice was much curtailed during the last five years because of the effects of extensive gastrointestinal surgery. During a vacation in Florida in February, 1957 he sustained a serious coronary thrombosis and had several lesser attacks since until the final one came on September 3, 1957.

Dr. Moore was well liked by a large clientele of patients and gained their confidence in his quiet, gentle and unassuming manner. He was a keen observer with a very retentive memory with regard to the past illnesses of his patients. Those of us who

substituted for him during his illness were made cognizant of this when later reviewing the cases with him. He was devoted to good record keeping, always a fine collaborator and never a competitor. His loss, particularly in the immediate neighborhood, is keenly felt. He was far from dramatic in his practice, was always surefooted and capable of accomplishing a good day's work without apparent effort. The art of medicine was inborn in him and he had a fine mind for retaining the scientific part for practical use.

Dr. Moore was the son of the late John Moore, a detective on the New Haven Police Force, and the late Ellen McNamara. He leaves his wife, the former Margaret Donlon, a graduate of Nursing School of the Hospital of St. Raphael, and two daughters, Elizabeth, eleven years old, and Margaret, sixteen years old. He is also survived by four brothers and one sister.

Michael S. Shea, M.D.

Hazen Albert Calhoun, M.D.

1907 - 1957

In the early morning hours of June 7, 1957 Dr. Hazen Albert Calhoun died within a few minutes after the onset of acute coronary thrombosis. He was on a vacation trip with his wife and was staying with relatives in Watertown, Massachusetts. He had been actively engaged in the practice of general medicine in the Higginum-Haddam area of Middlesex County up to the time of his death. He was fifty years old and his sudden and premature death was a profound shock to all his many friends and associates.

Dr. Calhoun was born in Providence, Rhode Island on December 10, 1907, the son of Rev. and Mrs. Hazen A. Calhoun. In early life he moved with his family to Woodstock, Connecticut where his father was pastor of the First Baptist Church and he lived his boyhood in the quiet religious atmosphere of this small community. Here he received his elementary education and here too the ideals which dominated his entire life were formed. He was greatly devoted to the members of his family and this keen devotion continued throughout his life. Here he found the joy of country living and later elected to spend his professional life in a small community.

His secondary education was also received in Woodstock. In 1930 he received a Bachelor of

Science degree from Colby College in Waterville, Maine, and the following year entered Tufts Medical School in Boston, Massachusetts. Upon receiving his Doctor of Medicine degree from Tufts in 1934 he entered upon a rotating internship in the Middlesex Memorial Hospital in Middletown, Connecticut. Following this he studied for several months at the New York Post Graduate Medical School and Hospital in New York City.

In 1936 Dr. Calhoun began the private practice of medicine in Middletown and was elected to the attending staff in medicine at the Middlesex Memorial Hospital, serving until 1943. In this year he entered the Medical Corps of the United States Army and served throughout the duration of World War II. He held the rank of captain, serving in this country, in the European theater and as an army surgeon aboard ship for the care of troops in transport. He continued his interest in military affairs upon his separation from the Army and was active in local veteran organizations.

His quiet unassuming manner as well as his sincerity and ability won the esteem of his fellow physicians who elected him for several years as secretary of the Central Medical Society and named him to several committees of the Middlesex County Medical Association. He was a member of the Connecticut State Medical Society and the American Medical Association.

Dr. Calhoun was active in the civic affairs of the community, ably participating in the school building programs and in the activities of the various voluntary health agencies. The Higginum Congregational Church designated him a deacon and he was serving in this capacity at the time of his death.

His neighbors and his patients showed great devotion for Dr. Calhoun and he gave generously of his time for their health and their welfare. He was nearly always near by and took but few vacations lest his help be needed. His influence for good was strongly felt and the esteem in which he was held extended even to the children who raised a fund as a memorial to him.

Hazen Calhoun was most devoted to his family: his wife and three children who survive him. His wife was the former Laura Campbell of Watertown, Massachusetts. An older son, Hazen III, is serving in the United States Air Force. A younger son, John C., and a daughter Marilyn are students in high school.

It is fitting to say that the loss of this splendid gentleman who possessed such richness of character and who served his family and community so well will truly be keenly felt.

Harold E. Speight, M.D.

Jack Sutton, M.D.

1917 - 1957



On September 21, 1957 Dr. Jack Sutton died suddenly as a result of a myocardial infarction at the early age of 39 years. He had just delivered a baby and returned to the doctors' dressing room in the Lawrence Memorial Hospital when he complained of feeling ill and lay down to rest. He expired a few minutes later. In him the community lost a devoted general practitioner, a man of stature and integrity, of clearness of mind and of moral courage. To say that he was a conscientious physician is an understatement. His many patients knew that they could count on him when sickness struck, whether by day or in the middle of the night. They loved him and trusted him. His mere sight would give them courage and hope. He always knew how to arrange matters to his patients' greatest advantage. To him they were not only patients but they were also his friends.

Born in Lodz, Poland on December 25, 1917, he received his high school and college education there. In 1936 he enrolled as a medical student at the University of Vienna, Austria, and in 1938 transferred to Basel, Switzerland. The outbreak of World

War II found him visiting his parents in Palestine, and he remained in that country until he came to the United States in June, 1943. He joined the American Army as a private in December, 1943 and was sent overseas in June, 1944. He saw action in France and Germany and was separated from the service in June, 1946. After a brief stay in this country, he returned to Switzerland to resume the study of medicine which was interrupted in 1939. He graduated from the Medical Faculty of the University in Bern, Switzerland in June, 1949 and returned to the United States to start an internship at the Greenpoint Hospital in Brooklyn, N. Y. After completion of his internship there he became a house physician at the Park East Hospital in New York City. In May, 1952 he opened an office practice in Groton, Connecticut. In a relatively short time he became a very busy general practitioner. His colleagues held him in high esteem.

His friends will always remember his quiet, unassuming manner, his good sense of humor, his devotion to his duties. He was an exemplary husband, father, son and brother.

He leaves his wife, the former Anna Leichtag and two small children, Robert E. and Debra M. Sutton, his mother, Mrs. Fannie Sutton and two brothers, Leon Sutton and Dr. Paul Sutton.

Hilliard Spitz, M.D.

Robert T. Henkle, M.D.

Blue Cross Rise in Rates Opposed in Philadelphia

Blue Cross has announced a proposed increase in rates which would raise the cost of Blue Cross hospitalization coverage from 42 to 71 per cent in various categories. Both the Pennsylvania State Insurance Commission and the New York Insurance Department have scheduled hearings on the rate increase. The Philadelphia County Medical Society has joined the C.I.O. Industrial Union Council in opposing any rise in Blue Cross rates.

The "soundness" of social security depends on compulsion, high employment, and no wars.

WOMAN'S AUXILIARY

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Auxiliary Conference Report

The 14th annual conference of state presidents, presidents-elect, and national committee chairmen of the Woman's Auxiliary to the American Medical Association was held October 21-23, 1957 at the Drake Hotel, Chicago, Illinois. As our president-elect, Mrs. C. M. Gratz, was unable to attend the meetings I shall give you my resume of them. I am happy to tell you that Mrs. Gratz is with us today and she assures me that she is well on her way to a full recovery from her injuries.

This conference was planned to follow group discussion procedure and needed some training of personnel in advance. Therefore some of us arrived early and received training in methods from Dr. Martin P. Chworowsky, director, Albert M. Greenfield Center for Human Relations, University of Pennsylvania. Dr. Chworowsky was everpresent during the conference stimulating groups in their efforts, so that the conference members in turn could return to their various states and follow such a conference concept.

Following a continental breakfast and registration on Monday morning the Conference was called to order by the President, Mrs. Paul C. Craig. The usual opening session followed after which the President-Elect, Mrs. E. Arthur Underwood, introduced Ernest B. Howard, M.D., assistant secretary, American Medical Association, who spoke on AMA Round-Up.

The most important issue before us, according to Dr. Howard, is the Forand bill, which is a proposed amendment to the Social Security Act. This bill provides hospital and medical benefits through old age and survivor insurance (OASI). This bill, to be introduced in Congress in January, is like the Murray Wagner Dingle bill. Though it has less

scope it would provide the same things. It is supported by labor. The bill allows 60 days free hospital care, and 60 days free care in an accredited nursing home in any one year. The federal government would pay for such care out of SS funds. It provides surgical care in hospitals by certified surgeons (other surgeons only in an emergency). Payments would be made to anyone who has SS or is eligible to receive it. You go to the hospital and now the government would pay the bill; the hospitals would be in contract with the government; fees to the doctors would be set by the secretary of Health, Education and Welfare. We must remember that this bill makes no provision for the indigents. We must train people to save money for emergencies, to buy insurance voluntarily, to take care of their own families, and to handle local cases through the local government.

The relationship of the doctor to the union is crucial. The U.M.W. program of medical care for the unions has become highly restricted with respect to the choice by individuals of a doctor.

Today's Health now has a full time editor who was formerly with another magazine as a special feature editor and under his editorship gradual changes will occur.

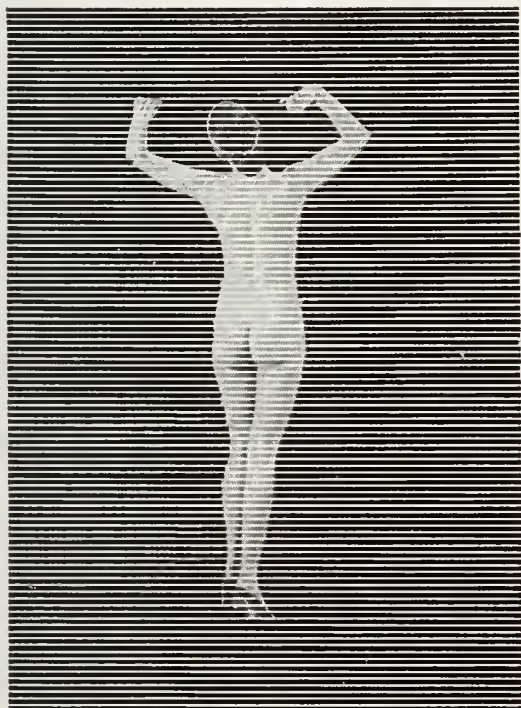
Pressures are splintering doctors on the question of social security for themselves, but anyone will understand clearly why the AMA opposes it by reading the three articles in the *AMA Journals* of October 12, 19 and 26.

With this briefing by Dr. Howard we were ready for our group discussions. After Dr. Chworowsky addressed the entire conference on group methods, those of us who had been trained previously presented several skits to illustrate his ideas more vividly.

David B. Allman, president of the American

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SEARLE

Medical Association, was the speaker at luncheon. He pointed out to us our auxiliary role in upholding the dignity of the medical profession to the public, and warned us that we must be well informed ourselves on medical legislation so that we can give the facts to the people.

Monday afternoon the conference broke into small discussion groups in which we were able to exchange problems and ideas with other states, learn new solutions to other questions, and seek the advice and help of the National officers, and resource people from AMA who were there.

In the evening another demonstration program was presented. The use of visual aids was explained and again some of us demonstrated the value of good parliamentary procedure and discussion.

Tuesday morning was a continuation of our group discussions. At luncheon we heard the president of the Auxiliary to the Student American Medical Association explain the origin and growth of that group. They want to learn the aims of the AMA and to prepare themselves to accept their responsibilities as doctors' wives.

"The Auxiliary and its Medical Society" was the subject for the panel discussion and summary of ideas which was held Tuesday afternoon. Dr. Howard moderated this panel and AMA staff members participated. Here are a few of the points brought out by this panel discussion. AMEF—The American Medical Education Foundation—is in no way competing with alumni funds. We know that about half the alumni do give to their medical schools' funds but 50 per cent do not and perhaps they will help through AMEF. All monies collected go directly to the medical schools.

Today's Health is being tested in some cities over 10,000 on newsstands which carry special magazines. By September of 1958 look for a change in the outside cover.

MEMBERSHIP

All auxiliaries have the problem of interesting members and keeping their interest. Try to challenge your doctors' wives to budget their volunteer time to include several fields.

LEGISLATION

Educate yourself and your husband; then you can talk to others.

RECRUITMENT

Science fairs have stimulated students to enter

medicine. Today 1 of every 1.7 students who apply to enter medical school are accepted. By 1960 we shall need more facilities for them. Recruit in all allied medical fields.

EXHIBITS

AMA has a wealth of exhibit material for local use. Remember to use it to educate your members as well as others.

SAFETY

Practice safe driving and safety at home. Michigan now requires every high school student under the age of 18 to have a driver education course (both in public and parochial schools). 11,000 high schools taught driver education last year but 10,000 more should have had courses.

CIVIL DEFENSE

Prepare your own emergency kit for home and car; cooperate with local civil defense authorities.

A delightful sherry party given by the president, Mrs. Craig, and the president-elect, Mrs. Underwood, concluded the conference activities for Tuesday.

Wednesday morning was devoted to a session on films and how to use them. Unfortunately this meeting I cannot report.

The conference was again a stimulating and very worthwhile experience for me. I am grateful for the opportunity to attend it. Thank you.

Mrs. Paul W. Tisher, president

The government, while slow to acknowledge anything wrong with the Social Security System, underestimated the demand for benefits. Women who could obtain benefits at 62, 63, and 64 decided to do so even if the payments were less than they would be at 65. Farmers suddenly turned out to be older than expected. Some began to pay social security taxes on reported income of \$4,200 which exceeded their income in prior years. Then they applied for benefits after paying taxes for six quarters. Many people who had retired and were well beyond 65 years of age, dug up jobs for themselves and paid social security taxes for 18 months, thereby qualifying for benefits of from \$30 to \$108.50 monthly for life. Social security experts in making their cost projections underestimated the ingenuity of the American people when Federal giveaways are as widely advertised as are social security benefits.

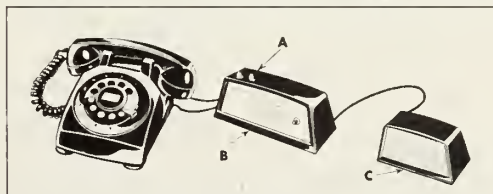


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You just press a button (A) and your voice is picked up by a microphone (B). The voice of the person you're speaking with comes through a small desk-top loudspeaker (C). (When you want privacy, the phone can be used in the conventional way.)

SPECIAL NOTICES

MIDDLESEX MEMORIAL HOSPITAL Medical Education Program for the Month of December 1957 — 12:00 Noon

- Monday, December 2
Clinical-pathological-conference
- Wednesday, December 4
Tumor conference (10:00 A. M.)
- Friday, December 6
Grand rounds
- Monday, December 9
Carcinoma of the lung
Dr. Donald R. Morrison of Hartford
- Friday, December 13
Grand rounds
- Monday, December 16
Diagnosis and treatment of different types of pneumonia
Dr. Elisha Atkins, Assistant Professor of Medicine,
Yale University School of Medicine
- Friday, December 20
Grand rounds
- Monday, December 23
Film: "Hypothyroidism"
- Friday, December 27
Grand rounds
- Monday, December 30
Holiday

18th ANNUAL CONGRESS OF INDUSTRIAL HEALTH, MILWAUKEE, WIS.

January 27-29, 1958

Maintaining high standards of health in industry will be a principal topic of consideration at the 18th annual Congress on Industrial Health to be held January 27-29 at the Schroeder Hotel in Milwaukee. Physicians, nurses, industrial hygienists, engineers and others interested in the field will attend the meeting sponsored by the AMA's Council on Industrial Health.

Recent developments in industrial health programs and various aspects of immunization programs in industry will be among the subjects covered by panelists at a special session cosponsored by chairmen of state medical society committees on industrial health. Other features include three technical sessions on (1) general aspects of disability evaluation; (2) industrial dermatitis, causes and evaluation of

disability; (3) low back pain, cause, treatment, evaluation of disability, rehabilitation.

AMERICAN COLLEGE OF SURGEONS New York, New York

Waldorf-Astoria Hotel, March 3-6

John H. Mulholland, chairman of the committee, anticipates an attendance of over 3,000 at this meeting. Careful scrutiny of the preliminary program indicates that all will be well repaid for time spent in the scientific sessions. This four-day session with hospital clinics, technical exhibits, separate sessions in surgical specialties, forum-type papers, and a special program for nurses will be held at the Waldorf-Astoria, Belmont Plaza, Commodore and Biltmore Hotels. The extensive Monday through Thursday program for nurses is being organized by a committee of New York's distinguished educators in the nursing field under the chairmanship of Ethel Jordan, Professor of Nursing at Skidmore College.

Morning hospital clinics are being prepared by staff representatives in hospitals readily accessible to the headquarters hotels. Programs in the specialties are planned under advice of the following authorities in their special fields: Bronson S. Ray (Neurological Surgery), Bernard J. Pisani (Obstetrics-Gynecology), Arthur G. DeVoe (Ophthalmology), T. Campbell Thompson (Orthopedic Surgery), John F. Daly (Otorhinolaryngology), Robert H. Wylie (Thoracic Surgery), and Victor F. Marshall (Urology).

THE AMERICAN SOCIETY FOR THE STUDY OF STERILITY

Beverly Hilton Hotel, Beverly Hills, California

CLINICAL DAY, FRIDAY, APRIL 18, 1958

Due to the overwhelming approval of the Clinic Day in New York, a number of sessions have been arranged at the following clinics: 1. California Institute of Technology Biology Laboratories. 2. Shelton Payne's Clinic. 3. Edward Tyler's Clinic. 4. University of California, Los Angeles Clinic. 5. Cedars of Lebanon Hospital Clinic. 6. Planned Parenthood Center Clinic.

Formal program: Beverly Hilton Hotel, L. A.

SATURDAY, APRIL 19

9:30-11:00

Male aspect of infertility

11:00-12:30 Panel:

Endocrine assays and their relation to the investigation and treatment of sterility

The panelists will be individuals with considerable experience in the pertinent laboratory fields who are also experienced in clinical medicine

Sealtest MILK "detective"



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Vitamin D Milk
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Fat-free Milk
Buttermilk
Chocolate Milk
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Every step from dairy farm to bottle or carton is under the trained eyes of Sealtest inspectors and laboratory and plant technicians.

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BRYANT & CHAPMAN
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Bridgeport, New Haven, Waterbury, Hartford, Manchester, Melrose,
New Britain and New London

GENERAL ICE CREAM DIVISION
National Dairy Products Corporation



12:30

President's luncheon:

Presentation of awards and introductions (ladies invited)

2:00-3:00 Panel:

The repeated abortion problem

This panel will be composed of individuals who are considered authorities on the psychogenic, genetic, endocrine and anatomical factors, concerned with this problem

3:30 Business meeting

SATURDAY NIGHT

Free time to enjoy Los Angeles night life

SUNDAY, APRIL 20

9:00 A. M.

Breakfast round tables.

Leaders will be physicians of repute. There will be no assigned subjects enabling those who attend the round table to discuss with the leader those things of greatest interest to them

10:30 Formal papers

12:30 Panel:

Management of menstrual disorders

During lunch several outstanding investigators will discuss the subject and answer questions

2:00 P. M.

Ayerst lecture:

The highlight of the meeting given by an eminent personality

SUNDAY EVENING

Cocktail party (for all registrants)

Excellent technical and scientific exhibits will be presented with ample time allowed for careful study.

AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

Sixth annual clinical meeting, Los Angeles, California, Hotel Statler, April 21-23, 1958.

FELLOWSHIPS IN RESPIRATORY DISEASES

The American Trudeau Society, (medical section of the National Tuberculosis Association) offers post-doctoral fellowships for training of clinicians, medical teachers, and scientific investigators in the field of tuberculosis and respiratory diseases. These awards make possible continuation of graduate study, oriented toward teaching or research, in an approved hospital or medical center.

Also available are a few fellowships at a higher level of training for specially qualified candidates with an M.D. de-

gree, who are assured of a continued teaching or research appointment upon completion of training. Predoctoral fellowships are also available to graduate students working for an advanced degree other than an M.D.

Awards are made to United States citizens for work in this country. Applicants must have the approval of the department heads under whom they expect to work. Fellowships are awarded for one year, but may be renewed up to a total of four years. Awards, determined on the basis of individual circumstances, are paid directly to the fellow on a quarterly basis.

Further particulars from: Director of Medical Education, American Trudeau Society, in care of the Henry Phipps Institute, 7th and Lombard Streets, Philadelphia, 47, Pennsylvania.

OUR NEIGHBORS

Harvard's New Medical Center

After years of effort including intensive study and consultation the Harvard Medical Center was incorporated in the summer of 1956. The Corporation merges the academic interests of the Harvard Medical School and seven Associated Teaching Hospitals in Boston.

To quote a recently published memorandum: "The Harvard Medical Center was formed to meet more effectively the many new social and economic stresses that have threatened the stability of medical education and research. The phenomenal growth of the natural sciences stands out as the driving force responsible for medicine's extraordinary advances during the decades since the end of the last century when the marriage of the laboratory and the clinic took place. In recent years the very excellence of American medicine has created the public's demand for more and more service—the right to good health is being accepted as a basic human right. The demand by the people for more and better medical service has stimulated an unprecedented outpouring of funds for research. Simultaneously, the continuing inflation has undermined the strength of privately endowed medical schools and hospitals. The ratio of 'hard' to 'soft' money has decreased despite strenuous efforts to build endowment funds. Capital has not grown fast enough to offset the falling value of the dollar."

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DENTOCAIN TEETHING LOTION

FORMULA—

Alcohol 70%
Benzocaine 10%
Chloroform, 4 mins. per fluidounce.

Easier on the Baby . . .

DENTOCAIN TEETHING LOTION makes it easier to go through the troublesome teething period. A small amount, applied with gentle massage, brings quick, soothing relief to irritated and inflamed gum tissue, aids in getting infant back to sleep.

Easier on the Mother . . .

By providing more comfort and extra sleep for the baby, DENTOCAIN TEETHING LOTION grants the mother greater peace of mind and several additional hours of necessary rest.

DENTOCAIN has also been useful in providing temporary relief for pain of adult toothache.



Dentocain Co., Hartford, Conn., U.S.A.

Professional samples and descriptive literature sent on request.

AROUND THE STATE



Standing left to right: Richard Elgosin, Hamden, past-president; John Monacello, Windsor, secretary; Peter Scafarello, Hartford, treasurer
Sitting left to right: Edwin Trautman, Trumbull, president; Joseph Massaro, Manchester, president-elect

General Practitioners Elect

About 100 general practitioners and their wives attended the annual meeting of the Connecticut Academy of General Practice held at the Waverly Inn, Cheshire, on October 6.

The following officers were elected for the ensuing year: President, Edwin F. Trautman, Trumbull; President-Elect, Joseph P. Massaro, Manchester; Secretary, John Monacello, Windsor; Treasurer, Peter J. Scafarello, Hartford. Delegates to National Convention: Edwin R. Connors, Bridgeport, and Peter J. Scafarello, Hartford. Alternate Delegates to National Convention: Edmund L. Douglass, Groton, and Joseph P. Massaro, Manchester. The new member to the Board of Directors for a three year term is Morris Sulman, New London.

Connecticut Advisory Committee on Foods and Drugs

Meeting of July 25, 1957

The member societies and institutions and the State agencies were represented at this meeting as follows: Con-

necticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut State Medical Society, Dr. Hugh L. Dwyer, Jr.; Connecticut State Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; Food and Drug Commission, Mr. Herbert Plank; State Department of Health, Dr. James C. Hart; University of Connecticut, Dr. Stanley F. Wedberg; University of Connecticut College of Pharmacy, Dr. Harold G. Hewitt; Yale University School of Medicine, Dr. Nicholas Giarmann.

Dr. Desmond Bonnycastle, former representative of the Yale University School of Medicine, and Dr. Benjamin Katzin, chairman of the Joint Committee of the State Medical Society and the Dental and Pharmaceutical Associations, were also present.

SUPER-CORONAID

Dr. Dwyer reported that Dr. Geiger and he had studied the advertisement for this product (which had replaced the "Coroneed" reported on at the October 4, 1956 meeting) submitted by Mr. Plank; in their opinion this advertisement was filled with misrepresentation of facts and was designed to exploit popular concern over heart disease. He said that the relationship between serum lipids (including cholesterol) and coronary disease was still in the speculative and investigative stage. Of greater significance was the fact that there was little or no evidence to suggest that the ingredients of "Super-Coronaoid" could alter the course of coronary artery disease. He added further that this product represented an exploitation of the current interest and anxiety concerning coronary disease in general and its dietary relationships in particular. He also stated that the advertisement claimed that "confidence and pep" were produced almost from the start of taking "Super-Coronaoid." Other statements implied, if they did not actually state, that the course of one's health would be affected by following this "plan." This advertisement was a misrepresentation of fact.

It was voted, on motion of Hewitt seconded by DeVita, that the Committee approve the report of Drs. Dwyer and Geiger.

REGIMEN DIET TABLETS

Dr. Hart reported for the subcommittee composed of Drs. Fisher, Giarmann and himself. He stated that the "Regimen" package contained three different kinds of tablets, whose compositions were as follows:

Do You Face This PROBLEM?

Like other busy people, doctors may find there "just aren't enough hours in the day." Something must be neglected. Often it's their investments.

If you face this problem, why not find out about the Agency Account service of the Hartford National Bank and Trust Company? An Agency Account with one of New England's leading banks relieves you of *all* the burdensome details of investment management. You have a complete record of income received and all transactions for your account . . . a great convenience at income tax time.

Investment Advisory Service

Included with your Agency Account is our Investment Advisory Service. You may, however, limit our functions to Investment Advisory Service if you prefer to collect your own dividends. This service gives you the benefit of the experienced judgment of our Trust Investment Committee in a continuing review of your investments. We would also hold your securities and arrange the brokerage transactions subject to your approval.

Cost of these services is low, and under present Federal Income Tax laws, may be deducted in determining taxable investment income. So, why not get full information, now? Ask for a copy of our booklet: "Your Financial Secretary." Call, write or use the coupon below.

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AND A MOST
COMFORTABLE NIGHT'S SLEEP

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First mattress designed in cooperation with leading orthopedic surgeons, this scientifically developed, firm mattress has afforded relief from morning backache frequently associated with too soft, sagging mattresses.

Not just a firmer mattress, not just a mattress that's been hardened up . . . the Sealy Posturepedic provides over-all support and comfortable resiliency—regardless of the sleeper's size or weight.

**Due to sleeping on a too-soft mattress*

SAVE \$39 WITH THIS SPECIAL PROFESSIONAL DISCOUNT!

SEALY MATTRESS CO. • 79 Benedict St. • Waterbury, Conn.

Please send me full details on how I may obtain my Doctor's Discount and save \$39 on the purchase of a Sealy Posturepedic Mattress with Matching "Coil-on-coil" Foundation.

Name.....

Address.....

City.....Zone.....State.....

(1) Enteric-coated pink tablets containing 0.648 Gm. of ammonium chloride, claimed to aid in the loss of excess fluids from the body (Dr. Hart remarked that any such loss would be only temporary).

(2) Three green tablets, each containing 22.5 mg. of benzocaine (probably intended to anesthetize the salivary glands) plus vitamin D, thiamine, riboflavin, ascorbic acid, vitamin B₆, calcium pantothenate, niacinamide and malt diastase.

(3) Three yellow tablets, each containing 90.0 mg. of anhydrous caffeine and 75 mg. of phenylpropanolamine hydrochloride, together with 10 mg. of iron (as FeSO₄), 0.1 mg. each of copper (as CuSO₄) and iodine (as KI), and 7.5 mg. of manganese (as Mn SO₄).

Dr. Hart stated that the phenylpropanolamine in these tablets was intended to inhibit the appetite; he warned that this drug could have toxic effects, particularly where there was cardiac damage or hypertension.

Dr. Fisher read to the members Information Letter No. 105 of the U. S. Food and Drug Administration. This official Government ruling permitted tablets containing phenylpropanolamine to be sold over the counter as appetite depressants, provided the dosage did not exceed three 25 mg. tablets a day. Since the "Regimen" directions called for taking only one 0.75 mg. tablet per day, the permitted total daily dose was not exceeded.

It was the subcommittee's conclusion that the "Regimen" advertising was false and misleading in that it gave the impression that it was possible to lose weight simply by using the tablets without cutting down on calorie consumption.

On motion of Dwyer, seconded by DeVita, it was voted that the "Regimen" advertising be declared false and misleading.

PSOREX SYSTEM

At the May 23 meeting it had been voted to ask Jack J. Albom, M.D. for an opinion on this product. Dr. Albom had been unable to attend the present meeting, but sent a written report which was read by the secretary. This report in summary was as follows:

"The 'Psorex System' involves application to the skin lesions of two preparations, whose 'active' ingredients are respectively salicylic acid and a garlic extract. Such benefit as this 'System' may have is due principally to the salicylic acid, which re-

moves the loose scales of this skin condition; there is nothing new in the use of salicylic acid for this purpose."

Secretary-Treasurer Fenney was directed to turn Dr. Albom's report over to Mr. Plank for such use as he wished to make of it.

It was voted that it be the Committee's opinion that the "Psorex System" advertising was false and misleading. The secretary-treasurer was directed to write Dr. Albom and express the Committee's thanks for his excellent report.

VETERINARY REMEDIES SOLD IN FEED STORES WITH IMPROPER LABELLING

Dr. DeVita gave a brief progress report on this subject, and stated that he would present a full report at a later meeting. He said that a number of products now being sold for the treatment of mastitis by intramammary injection were improperly labelled as regards indications for use, contra-indications to use, and name and address of the distributor. On some preparations there was an unqualified statement that topical use of antibiotics was harmless; this was not true.

TRANQUILIZERS

Dr. Giarnan presented for Dr. Dwyer and himself a written report on this subject, a copy of which is appended to this Report. He stated that no definition for "tranquilizers" had yet been accepted by authorities in the field, and added that many of the products such as "Tranquil" now being sold over the counter were actually borderline tranquilizers in his understanding of that term.

Dr. Dwyer remarked that "Miltown" and "Equanil" had given excellent results with some of his cases.

THE CONTRIBUTION OF DR. DE VITA TO PASSAGE OF THE HAZARDOUS SUBSTANCES LAW

Dr. Fisher remarked that although Representative Turner should receive much credit for his efforts to ensure passage of the Hazardous Substances bill, and although every member of the Committee had contributed something to this end, there was one Committee member in particular who was primarily responsible for the bill's final passage: Dr. Joseph DeVita. Dr. DeVita had originally accepted with reluctance the leadership of the Committee's campaign for the bill, but once he agreed to take the job he had been untiring in his efforts to further its passage; when help he had every reason to expect

*You can refer your patients, with
confidence, to members of*

THE CONNECTICUT HEARING AID SOCIETY

This Society was established to promote and maintain a professional level of conduct, and to encourage cooperation between hearing aid consultants and members of the Medical professions.

Society members agree to use audiometric test equipment to plot hearing loss before recommending use of hearing aids; teach the proper use of hearing aids; be honest in all advertising; and refer individuals needing medical attention to the Medical professions.



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sometimes failed him, and he met opposition from unexpected quarters, he never gave up, but inspired and shamed us all into following him to final victory. It was to express in some small measure our gratitude for his extraordinary services that the Committee had voted two years ago to break its longstanding precedent and elect him to a second term as chairman.

It was voted unanimously that the secretary-treasurer write Dr. DeVita and express on behalf of the Committee its recognition and grateful appreciation for his untiring efforts and his material and spiritual help in the passage of the Hazardous Substances Law.

Meeting of October 3, 1957

The member societies and institutions and the State agencies were represented at this meeting as follows: Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher; Connecticut State Dental Society, Dr. William Kirschner, Jr.; Connecticut State Pharmaceutical Association, Prof. Nicholas W. Fenney; Connecticut Veterinary Medical Association, Dr. Joseph DeVita; Food and Drug Commission, Mr. Herbert Plank; State Department of Health, Dr. James C. Hart; University of Connecticut, Dr. Stanley E. Wedberg; University of Connecticut School of Pharmacy, Dean Harold G. Hewitt.

Representative John McCullough Turner of Bethany was also present.

REGIMEN DIET TABLETS

Following the action of this Committee at its meeting on July 25, declaring the advertising for this product to be false and misleading, Mr. Plank reported that a small seizure was made. After a conference with representatives of the company manufacturing Regimen, it was agreed that future advertising would be submitted to the Food and Drug Commission for approval. Should such ads not be submitted and statements are made that do not meet with approval of the Commission, action against the company may be initiated once again.

PSOREX SYSTEM

Similar action to that taken against Regimen was instituted against this product after the opinion of the Advisory Committee on Foods and Drugs on July 25 indicated that advertising was false and misleading.

WASH-'N-DRI

The R. R. Williams Company of Canaan, Connecticut, has recently marketed a "Germicidal Wash-'n-Dri Miracle Moist Towelette" containing

alcohol, benzalkonium chloride, and chlorothymol, and the following inert ingredients: towelettes, water, propylene glycol, fragrance. Total inert: 89.8 per cent.

Within the package is a folder entitled: Asian influenza—preventive measures and treatment. Typical statements found in this folder include the following: "If coughing or sneezing is directed into Germicidal Wash-'n-Dri moist towelette, many bacteria and virus are almost immediately destroyed and the hands are protected from recontaminating the patient or from his contaminating other people." "Frequent washing of face and hands with Germicidal Wash-'n-Dri effectively destroys Asian influenza virus in seconds and leaves an invisible, imperceptible film which provides protection for hours."

Dr. Wedberg was instructed by the Advisory Committee to look into these claims and to report back at the next meeting.

EXERCYCLE

Mr. Plank reported for the information of the Committee that there had been a Federal seizure on this product (a form of bike for exercise), but no action was asked of our Committee.

Statement on Tranquilizing Drugs and "Tranquil"

There is almost universal acceptance today of the efficacy of *bona fide* tranquillizing drugs in some of the psychoses and in some neuroses and minor functional disturbances. However, the specific indications for their use are still more or less in a chaotic state; and their relative value in the neuroses is far from being adequately assessed. The American Psychiatric Association, in a recent statement, has pointed out the tremendous demand by the public to use these drugs for the relief of common anxiety, emotional upsets, nervousness, and routine tensions of everyday living. The statement deplores the use of the drugs in this manner as being medically unsound and constituting a public danger.

Data from the New York City Health Department according to the records of the Poison Control Center indicate the nature of the growing hazard:

	YEAR	FIRST 10½ MONTHS
	1955	1956
Cases of poisoning	12	76
Fatalities	0	2
Attempted suicides	0	16

Another problem which has arisen and bears upon the case of "Tranquil" is that a strict definition of

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tranquillizing drugs either on a clinical or neuropharmacological level is very difficult. The lay press refers to these agents as "happiness pills." The one clinical definition offered is "any drug given for the purpose of making a person feel better when he is tense." The major difficulty in this definition is obviously the fine line between tranquilization and sedation.

On the neuropharmacological level an analysis of the actions of clinically effective tranquilizers reveals that there are four general areas variably altered by these agents:

1. Complex of function related to degree of wakefulness.

2. Variety of autonomic functions.

3. Activity of striated muscle.

4. Responses related to pain

Some of the tranquilizers (e.g., reserpine and chlorpromazine) have activity in all four of these areas; others (e.g., meprobamate, benactyzine), in only one or two. At this stage of our knowledge then it is not surprising to find drug companies promoting as tranquilizers, pure sedatives or antihistamine compounds, which alter the degree of wakefulness and have autonomic activity.

A good case in point is "Tranquil," the brand name of the Alva Laboratories for their so-called tranquilizer, which contains scopolamine aminoxide (in minute doses); methapyriline (an antihistamine); sodium, potassium and ammonium bromides; and a wide variety of vitamins, minerals, and nutrient substances. Apart from the scopolamine, which probably exerts a minimal effect at the dose involved (0.1 microgram, q. 4h.), the really neuroactive ingredients, the bromides and methapyriline, represent simply a sedative mixture. In point of fact, probably the only ingredient in this formulation which could produce the complex of actions known as tranquilization is the scopolamine, but in order to achieve this effect the dose must be 200 to 600 micrograms and, since the scopolamine aminoxide has only one-third the potency of the alkaloid itself, even higher doses of the aminoxide might be necessary. The amount of the bromides present in "Tranquil," if taken as suggested, about four times a day, would total about 1 Gm. of bromide ion per day which upon chronic administration would lead to a state of sedation in three to five days. It is impossible to discuss the methapyriline in the "Tranquil" preparation because the amount of this agent

is not stated on the label. This is a serious omission and should be rectified. The usual amount of methapyriline recommended for sedation is 25 mg. t.i.d. or q.i.d. This is the active agent and dose, for example, in another so-called "aid in the relief of nervous tension," "Paradorm," trade mark of Paradorm, Inc.

It is interesting to note that in a letter from Attorney Frank E. Gettleman of Chicago to Mr. Plank concerning "Tranquil," the preparation is repeatedly referred to as a "sedative," and not as the label states "a tranquilizing aid for relief in nervousness," suggesting a tranquilizer. As a sedative of the nonbarbiturate type, there is no question that "Tranquil" is free from restriction by the F.D.A. for over-the-counter sale. The problem lies, as it does in a large part of this field, in extravagant, distorted, and misleading claims for the product on the label and in the literature from the drug houses.

The discussion in Mr. Gettleman's letter concerning the vitamin and nutrient constituents of "Tranquil" is difficult to comment on. Most authorities agree that certain vitamins are essential for the proper functioning of the nervous system. Whether vitamins have a place in the same formulation with sedative drugs is another problem. We think not. On the other hand, no real harm is done by such an inclusion, and we seriously doubt that anyone would take such a preparation for its vitamin content alone with the multiplicity of pure vitamin preparations on the market.

In view of the foregoing, it would appear that our only recommendation concerning "Tranquil" should be to urge inclusion on the label of the total amount of methapyriline in each "Tranquil" tablet. If this is in a safe range, no further recommendation seems warranted at this time. Unfortunately, until the phenomenon of tranquilization becomes better delineated, it is not even possible to suggest that the labelling of "Tranquil" is extravagant or misleading.

Nicholas J. Giarman

Hugh L. Dwyer, Jr.

Connecticut Regional Blood Program

The system of blood distribution in Connecticut differs widely from the normal conception of a central blood bank. Five years ago it was decided by the medical society that blood should be distributed to the hospitals of this State and not re-

NATCHAUG Convalescent Hospital, Inc.

A one-story, brick, fire resistant, ranch type, T shaped building; constructed, planned, and equipped by active physicians, to provide efficient individualized medical treatment and relaxing home like atmosphere, for convalescent and chronically ill, bed ridden or ambulatory patients.

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tained on the Hartford Center shelves. There are, therefore, approximately 2,500 pints of blood in forty hospital blood banks in the State at all times.

Each hospital blood bank level is annually set up on the basis of its actual usage of blood during the previous year plus 10 per cent to allow for variation in types and outdating. This annual figure is divided by 365 to give a daily usage and multiplied by 12 to denote a 12 day supply. Each hospital, on its weekly order, checks its inventory and orders up to the quantity required to bring the blood bank to a 12 day level. Naturally, due to varying usage of different types of blood, this does not eliminate emergency orders which are filled by other hospitals, the Hartford Center and walk in donors recruited by the Red Cross Chapters in that order. Emergency orders, however, have been much reduced since this system of storing blood at the point of usage was instituted.

	JULY 1, 1957 THROUGH	
DONORS	OCTOBER 1957	OCTOBER 31, 1957
Donors accepted	7,517	28,575
Donors rejected	786	2,810
Donors registered	8,303	31,385
BLOOD ISSUED TO HOSPITALS		
To Connecticut Hospitals from Center	6,562	25,172
Blood collected by hospitals.....	646	2,209
To fractionation stock pile.....	225	693
To out of state hospitals.....	82	326
	7,515	28,400
PROCESSING AT CENTER		
Processed into fresh frozen plasma.....	72	380
Processed into packed cells.....	3	7
Processed into liquid plasma.....	409	2,364
	484	2,751
Discarded—unfit and broken.....	31	146
Grand Total—distribution of blood.....	8,030	31,297
Blood returned to center for processing into plasma and fractions.....	421	2,387
BLOOD DERIVATIVES ISSUED TO HOSPITALS		
Irradiated plasma (300 cc.).....	55	209
Fresh frozen plasma (125 cc.).....	158	655
Serum albumin (100 cc.).....	98	390
Immune serum globulin (2 cc.).....	0	60
Packed red cells.....	3	7
Fibrinogen	0	0

Cancer Society News

The Cancer Society campaign broke all records in Connecticut this year by reaching a total of \$655,018 which was \$17,573 above the 1956 total and \$68,818 ahead of the projected goal. A total of 114 towns exceeded their quotas, 14 districts out of 19 attained quota breaking sums, 12 of them had record marks.

The new president of the Connecticut Society is Donald A. Bristoll of New Britain.

Dr. Marshall Pease Receives Honor

Marshall C. Pease of Ridgefield, exchange editor of the JOURNAL, was named by the American Academy of Pediatrics at its recent annual meeting in Chicago to receive the award for outstanding service to pediatrics. Dr. Pease has had a long and distinguished career. He has served as director of the pediatric service of the Danbury Hospital, as clinical professor of pediatrics at College of Physicians and Surgeons, Columbia University, and as consulting pediatrician at St. Vincent's Hospital, Bridgeport, Stamford Hospital and several hospitals in New York City. In addition to these he is a founder-member of the American Board of Pediatrics, a fellow of the American College of Physicians, a member of the Medical Advisory Committee of the Fairfield County Chapter of the National Foundation for Infantile Paralysis and formerly served on the staffs of the New York Post Graduate Hospital, the Willard Parker Hospital, Fitkin Hospital, Jamaica Hospital and Lutheran Hospital.

Home Care in Greenwich, Connecticut

The Greenwich Hospital's Home Care Program for chronically ill residents of the city is well into its second year of operation. The program was established on a three year pilot basis in January, 1956 as the result of a study conducted into the problems of long-term illness in Greenwich, and is one of an increasing number of such programs to keep patients under the management of their private physician while on home care. Referrals are accepted only from practicing physicians in the community. Another private practitioner serves as coordinator of the program, and is responsible for integrating the various nursing, social and rehabilitation services which may be requested by the patient's personal

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physician. These services, which are provided by the hospital and other public and voluntary agencies in the community, are partially paid for by patients and by state and local welfare agencies for their clients. The remaining costs are met through a grant to the hospital.

During the first year of operation, 25 patients were admitted to the program, and ten of these were subsequently discharged with the following dispositions: seven were sufficiently rehabilitated to receive services from other community agencies; two were terminal cases and subsequently died at home; and one was readmitted to the hospital.

Fairfield County

Louis Rogol of Danbury was elected chairman of the Danbury Hospital medical staff at its annual meeting on October 15. At the same meeting Ward B. DeKlyn was elected vice chairman and Hugh S. P. Binnie, secretary and treasurer. Dr. Rogol is at present chairman of the Board of Trustees of the Fairfield County Medical Association.

A Stamford general practitioner, Albert P. C. Kezel, was elected to the Board of Education in that city in the November elections. He takes office this month and will serve for three years. Figures reveal that the Stamford physician was the leading vote getter for his party in the contests for posts on the board. This was his first attempt for office.

President R. Harold Lockhart has been authorized by the Board of Trustees to appoint six members to a committee representing the Fairfield County Medical Association in a medical-legal relations body. The Fairfield County Bar Association is expected to name a similar group composed of attorneys from Fairfield County. It was reported that a similar move had been initiated by the Stamford Bar Association for a local level medical-legal liaison group. Shown before the bar meeting at that time was the film "The Medical Witness" produced under the auspices of the American Medical Association and the American Bar Association.

Winner of the Mullins golf trophy at the semi-annual meeting of the Fairfield County Medical Association held at the Round Hill Club in Greenwich in October was John G. Frothingham, New Canaan.

Dr. Osborn Honored by Nurses

Stanley H. Osborn, State Health Department commissioner was tendered an honorary member-

ship in the Connecticut State Nurses Association at a dinner held in Hartford during the recent annual convention of the Association. Dr. Osborn has the distinction of being the first individual, not a nurse, to receive this honorary recognition, given because of his "superior contribution to the health of the citizens of Connecticut." Creighton Barker was master of ceremonies. Miss Agnes Ohlson, chief examiner of the State Board of Nurse Examiners, was the recipient of a plaque at the same dinner.

Hartford County

C. Leonard Smith of West Hartford, a radiologist on the staff of the Hartford Hospital died at that institution on October 18 at the age of 46.

Norman J. Barker, medical director of the Connecticut General Life Insurance Company, is the new president of the Association of Life Insurance Medical Directors, elected at the annual meeting in New York in October.

Donald A. Bristoll of New Britain was elected president of the Connecticut Cancer Society at its annual meeting in New Haven in October.

Lawrence P. Cogswell of Hartford has been appointed physician for the University of Connecticut. He will be available to students, faculty and staff members at his office in Hartford.

Roger G. Conant of West Hartford has received the appointment as medical director of Royal McBee Corporation. In this post Dr. Conant will direct a staff of ten responsible for a comprehensive health program of Royal McBee's 6,000 employees in Hartford.

At the recent annual meeting of the Hartford Hospital medical and surgical staff Ralph T. Ogden was reelected president and R. Starr Lampson reelected secretary. Robert G. Reynolds was chosen as vice president. The surgical division will be headed by Charles S. Mirabile and the medical division by Burdette J. Buck.

John F. Reed of Wethersfield has been reelected president of the Hartford Branch of the Connecticut Cancer Society. John Shoukimas of Hartford was elected vice president and Ralph T. Ogden of Hartford chosen as representative to the State cancer organization.

Fowler White of West Hartford has been appointed medical examiner for West Hartford.

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1. Hodges, F. T.: GP, 14:86, Nov., 1956.
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Middlesex County

Francis Korn was recently certified as a specialist by the American Board of Radiology.

"Nephrosis in the Newborn Infant," an article in the August *AMA Journal of Diseases of Children*, was co-authored by Andrew Turano.

William Irving is reopening an office for the practice of pediatrics in Saybrook.

Paul Hunter, who was associated with Charles W. Chace in Middletown, has now opened his own office in Higganum.

The semi-annual meeting of the Middlesex County Medical Association was held at the Commodore Macdonough Inn on October 10. The speaker was Raymond Moeller and his talk was called "All In the Same Boat." The new members who were voted into the organization are: David C. Harvey, Paul Hunter, Gordon J. LaVelle, Herbert M. Magram, Joseph A. Manzi and Richard T. Sweet.

Donald Arnault and Vincent J. Vinci attended the Clinical Congress of the American College of Surgeons in Atlantic City in mid-October.

Herbert Levine attended the annual meeting of the American Heart Association in Chicago the last week in October.

New Haven County

Russell V. Fuldner of New Haven is the author of "Labor Complications and Cerebral Palsy" pub-

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lished in the July, 1957 issue of *American Journal of Obstetrics and Gynecology*.

On the panel, "Tuberculin Testing Today," at the New England Tuberculosis Conference held in Groton in September, Arnold Rilance of the Tuberculosis Control Office in New Haven was one of the participants. Professor Ira Hiscock of Yale summarized what transpired at the Conference at the closing luncheon.

Mark A. Hayes of New Haven was elected first vice president of the Connecticut Cancer Society at its annual meeting in New Haven in October.

Albert W. Snoke, director of Grace-New Haven Community Hospital, is the author of "A Cliche For Today" published in *Trustee*, June, 1957.

GOLDEN JUBILEE AT ST. RAPHAEL'S

The Hospital of St. Raphael, New Haven, celebrated its Golden Jubilee in October. Francis J. Braceland, psychiatrist in chief of the Institute of Living, Hartford, and Archbishop O'Brien, president of the Hospital's Board of Trustees, were the principal speakers at the opening banquet. This was followed next morning by a solemn high mass of thanksgiving celebrated by the archbishop and the following day by a scientific program. The final event on the program was a jubilee luncheon for all hospital personnel.

NEW BOOKS IN REVIEW

THE CHRONICALLY ILL. By Joseph Fox, M.A., Ph.D., Executive Director of the Home for Chronic Sick in Irvington, New Jersey. New York: Philosophical Library, Inc. 1957. Pp. 229. \$3.95.

Reviewed by JAMES R. MILLER

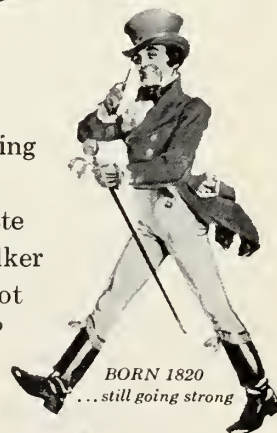
Dr. Fox has produced a book that needed to be written even though there is currently a flood of literature on this subject. This book is particularly "good medicine" for a hospital administrator or trustee who "still looks upon 'chronic' patients as a poor investment, requiring separate and inexpensive kinds of philanthropy to house them" and who "still makes the tragic mistake of equating 'acute' with 'curable' and 'chronic' with 'incurable' when he formulates or perpetuates hospital policy."

Programs for the aged and for the chronically ill are developing rapidly and this well written manual can advantageously be put into the hands of those who carry the responsibility of shaping these programs, so that costly mistakes due to unfamiliarity with the experience of others may be avoided. "The story of man's response to the challenge of physical misfortune is really a universal one and it is a thrilling story."

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Separate chapters are devoted to the scope of chronic illness, the various kinds of diseases, the crises that they cause in the life of the individual and the various facilities that are available for his long-term care. Rehabilitation is discussed in a chapter called "taking up life again," and the relation of the aging process, of economic and sociological factors are treated as fully as is required to orient the reader to the best present day thought.

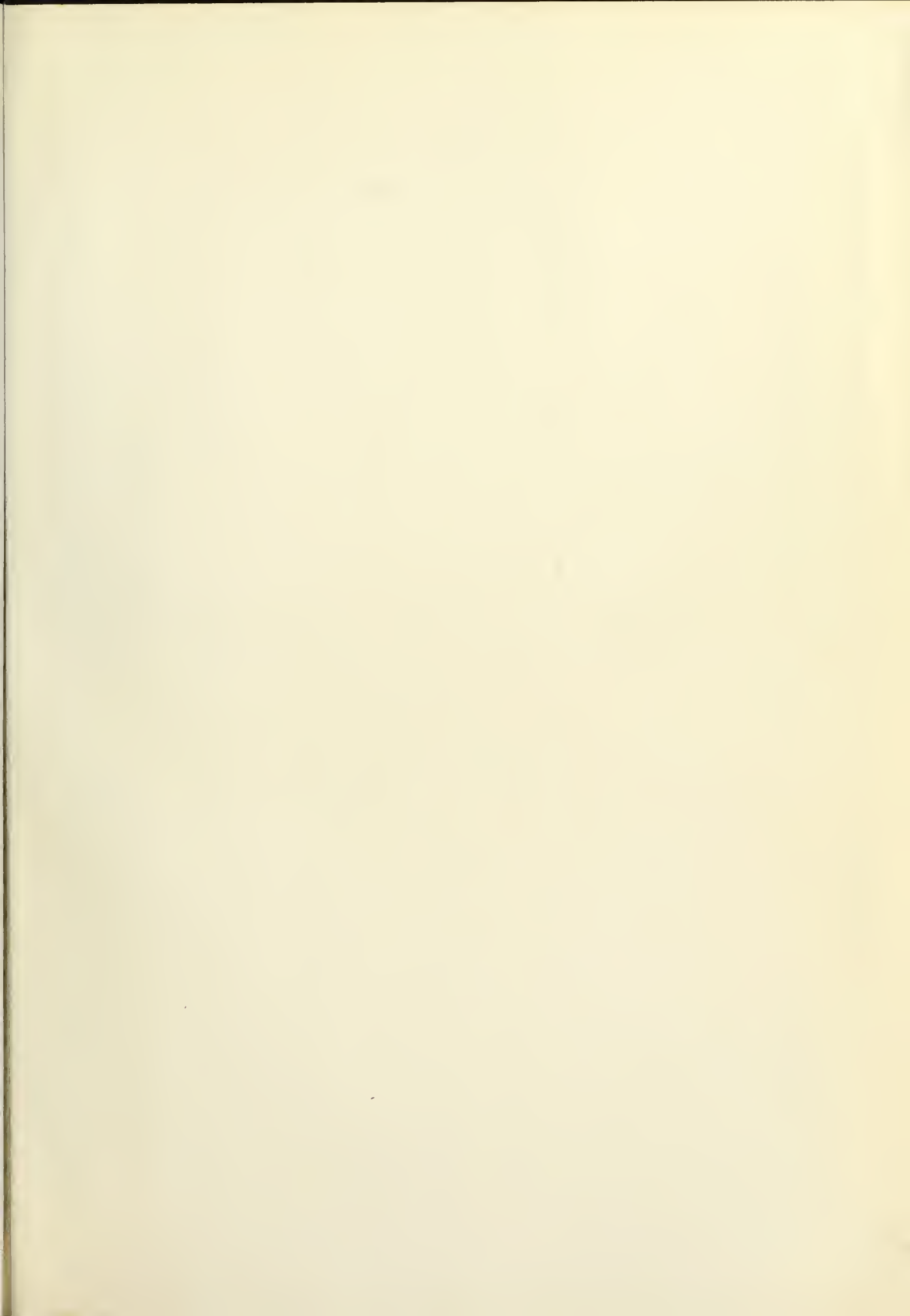
It is doubtful that Dr. Fox could have spoken as comprehensively and with such authority had he not drawn extensively from the studies of the Commission on Chronic Illness. The recommendations and the principles adopted by that commission are made available to the reader in doses that are easy to take. The concluding chapter sums up the life work of Dr. Bluestone and describes the organization of the Montefiore Hospital and of its Home Care Service, without which no consideration of chronic illness would be complete. "The time has arrived," he says, "when the hospital must, on occasion, go to the patient." This idea of extra-mural, community responsibility has been slow in catching on, but eventually must be accepted if the general hospitals are to be something more than "glorified first aid stations."

At the end of each chapter and again at the end of the book there is a well chosen bibliography, to substantiate

the text and to enable the reader to become well read in this field. There is a glossary also which will help the lay reader with some of the important medical terms. Exception is taken to the definition of "custodial case," as one that is left with a "burnt-out disease." This is more picturesque than exact, for it does not include the idea of dependency.

Dr. Fox writes with a background of institutional experience and with the training of a sociologist. This is a view which is not always easy for a physician to acquire, and we are indebted to him for it. In Connecticut we miss a discussion of the significant changes that follow the great reduction in demand for sanatorium beds for tuberculous patients. Are these wonderful hospitals, often situated in places remote from civilization, going to be adaptable to the treatment of chronic illnesses other than tuberculosis? Perhaps it is not fair to raise this question for Dr. Fox's book was undoubtedly in press before our new Commission on Tuberculosis and Other Chronic Illness was organized. For several years, however, the handwriting has been on the wall and it would be a mistake for anyone to read this book unaware of this important change.

The book itself is well printed and only one error was noted, viz., on page 90 Leonard W. Mayo is incorrectly spelled and incorrectly indexed.







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